

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 Wk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ESTHER McNEILL Bailey				4. DATE OF DEATH Month Day Year August 25-1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-6-1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John McNeil				14. MOTHER'S MAIDEN NAME Susan Reid			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. R. Herman Hodgson, Same Address B			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Atherosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/20/60 to 8/25/60 , that (I) (we) lost the deceased alive on 8/25/60 , and that death occurred at 4:30 M. from the causes and on the date stated above.							
22a. SIGNATURE AC Mitchell				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-27-1960	
22c. PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell				22d. ADDRESS 211 Maryland Ave., Salisbury			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-30-1960		23c. NAME OF CEMETERY OR CREMATORY St. Philips Cemetery		23d. LOCATION (City, town, or county) (State) Quantico, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				25a. REC'D BY REGISTRAR AUG 31 '60		25b. REGISTRAR'S SIGNATURE Charles L. Hines	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09697

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1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>NEARLY</u> Last <u>BAILEY</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 6, 1883</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POLICE DEPARTMENT</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SEWELL H. BAILEY</u>				14. MOTHER'S MAIDEN NAME <u>CLARA NORTHAM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-10-3994</u>		17. INFORMANT <u>MRS HATTIE V. BAILEY</u> Address <u>403 WALNUT ST. POCOMOKE CITY, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Arteriosclerotic Heart Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>July 31, 1960</u> to <u>Aug 21, 1960</u> that (I) (we) last saw the deceased alive on <u>Aug. 20, 1960</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u>				22b. DATE SIGNED <u>8/21/60</u>		22c. PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE, M.D.</u>	
22d. ADDRESS <u>SALISBURY, MARYLAND</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-24-60</u>		23c. NAME OF CEMETERY <u>UNION GREENBACKVILLE</u>		23d. LOCATION (City, town, or county) <u>WORCESTER COUNTY, MARYLAND</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kneaf</u> ADDRESS <u>POCOMOKE CITY, MD.</u>				25a. REC'D BY REGISTRAR <u>AUG 25 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kneaf</u>	

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FOR STATE HEALTH DEPT.
TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

9729
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69698

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		d. STREET ADDRESS Route # 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Otho Barnes				4. DATE OF DEATH 8-5-60 19 60			
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-22-1910	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Norfleet Barnes				14. MOTHER'S MAIDEN NAME Ada Barnes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Alice Barnes, Berlin, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia- 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute methyl alcohol poisoning- DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer		EXAMINER'S NAME (Type) Earl L. Royer, M.D.		M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-11-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-10-60		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or country) (State) Berlin, Md.	
23. FUNERAL DIRECTOR Thornton Jolley		ADDRESS Salisbury, Md.		24a. REC'D BY REGISTRAR DATE AUG 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

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Mr. Alice Barker, Dallas, Tex.

Mr. Barker

Constitutional, Virginia

Laborer

0-22-1010

Barber

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Evolutionary General Hospital

Room 23

Address

Marital

Occupation

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9773

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09699

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>New Church</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>Sta 83X-3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE W. BONNERVILLE</u>				4. DATE OF DEATH Month Day Year <u>August 22 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22, 1905</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House-work</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ELIZAH MARSHALL</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Broughton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>229-09-6313</u>		17. INFORMANT Address <u>James Marshall - New Church, VA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X Congestive Failure</u> DUE TO (b) <u>Uremia</u> DUE TO (c) <u>Chronic Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Uremic Bleeding</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> <u>1960</u> to <u>8/22</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>8/22</u> <u>1960</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WARDTOWN</u>		23d. LOCATION (City, town, or county) (State) <u>Pocomoke md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, VA.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 26 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. D. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09700

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		1939-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hayward Ave.				d. STREET ADDRESS Laird Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARRIETT EMMA CATLIN				4. DATE OF DEATH Month Day Year August 4 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1867		9. AGE (In years lost birthday) 93 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Fairmount, Somerset- Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Revelle				14. MOTHER'S MAIDEN NAME Nancy Bozman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-07-5969A		17. INFORMANT Address Mrs. Clarence Byrd--Hayward Ave.--Fruitland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420-1 IMMEDIATE CAUSE (a) Coronary artery occlusion DUE TO (b) generalized arteriosclerosis DUE TO (c) Diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 5 min. ? yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1960 to Aug 1960 , that (I) (we) last saw the deceased alive on 30 July 1960 , and that death occurred at 3:15 PM , from the causes and on the date stated above.							
22a. SIGNATURE Robert T. Adkins				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6 Aug '60	
22c. PHYSICIAN'S NAME (Type) ROBERT T. Adkins, M. D.				22d. ADDRESS Fruitland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 6, 1960		23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		23d. LOCATION (City, town, or county) (State) Crisfield, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.				ADDRESS		25a. REC'D BY REGISTRAR AUG 16 '60	
						25b. REGISTRAR'S SIGNATURE Arthur L. Howard	



9730

CERTIFICATE OF DEATH

09791

Reg. Dist. No.

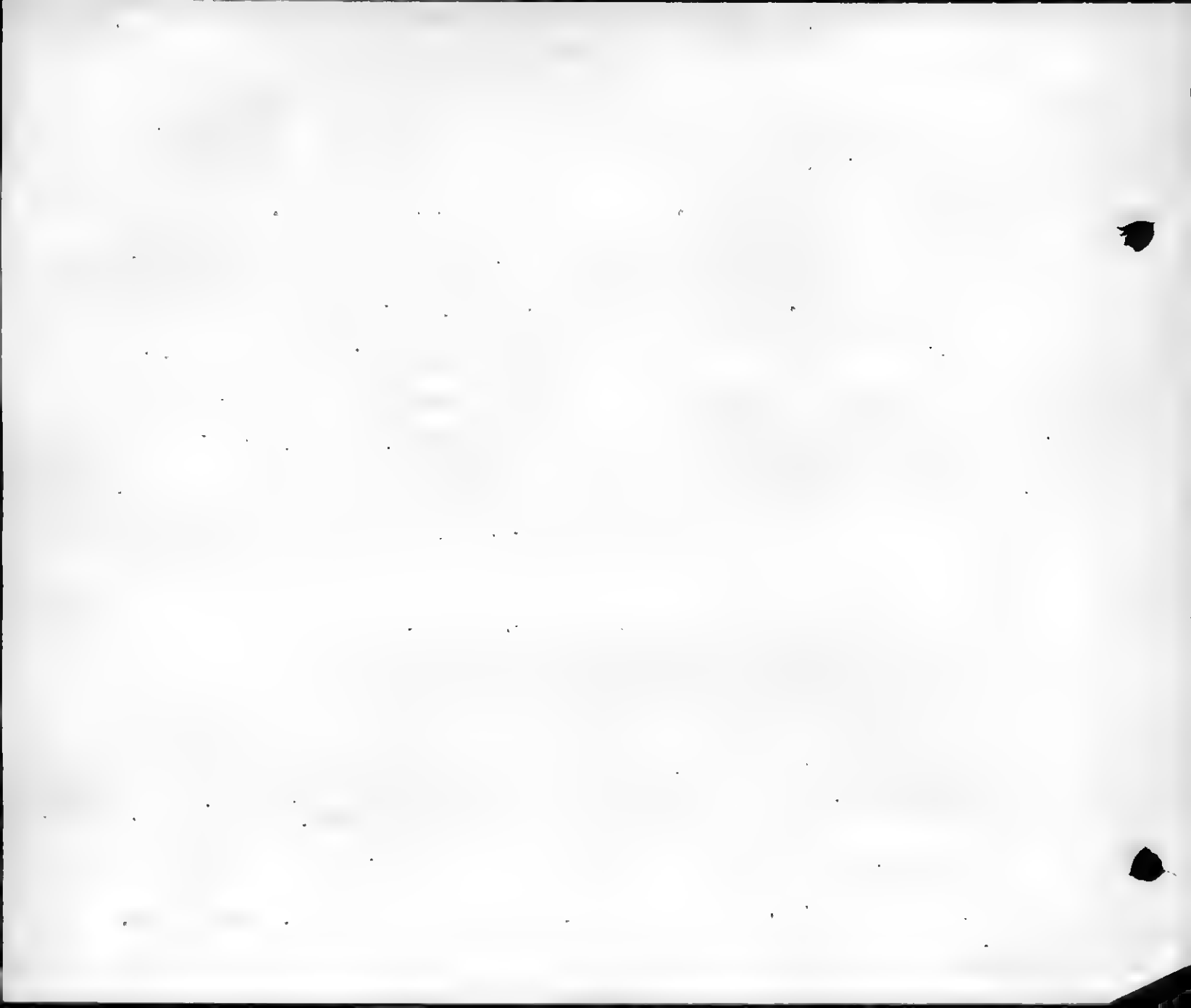
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>408 Stewart Pl.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gladys M. Collins</u>				4. DATE OF DEATH Month Day Year <u>August 2 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 17, 1903</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Thomas Bevans</u>			
14. MOTHER'S MAIDEN NAME <u>Levenia Parker</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>George Collins 408 Stewart Pl.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>400.0 Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease 10 years</u> (c) <u>Cardiac decompensation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1960</u> to <u>August 2, 1960</u> , that I last saw the deceased alive on <u>July 30, 1960</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L.V. Sohl</u> M.D.				ADDRESS (Street, city or town, state) <u>303 East Street</u> DATE SIGNED <u>10-8-60</u>			
PHYSICIAN'S NAME (Type) <u>L.V. Sohl M.D.</u>				DECEASED'S NAME (Type) <u>Delmar, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glass Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Parsonsburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 15 '60</u>			
ADDRESS <u>Salisbury Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

1

TO HOSTS: ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
M 9/58

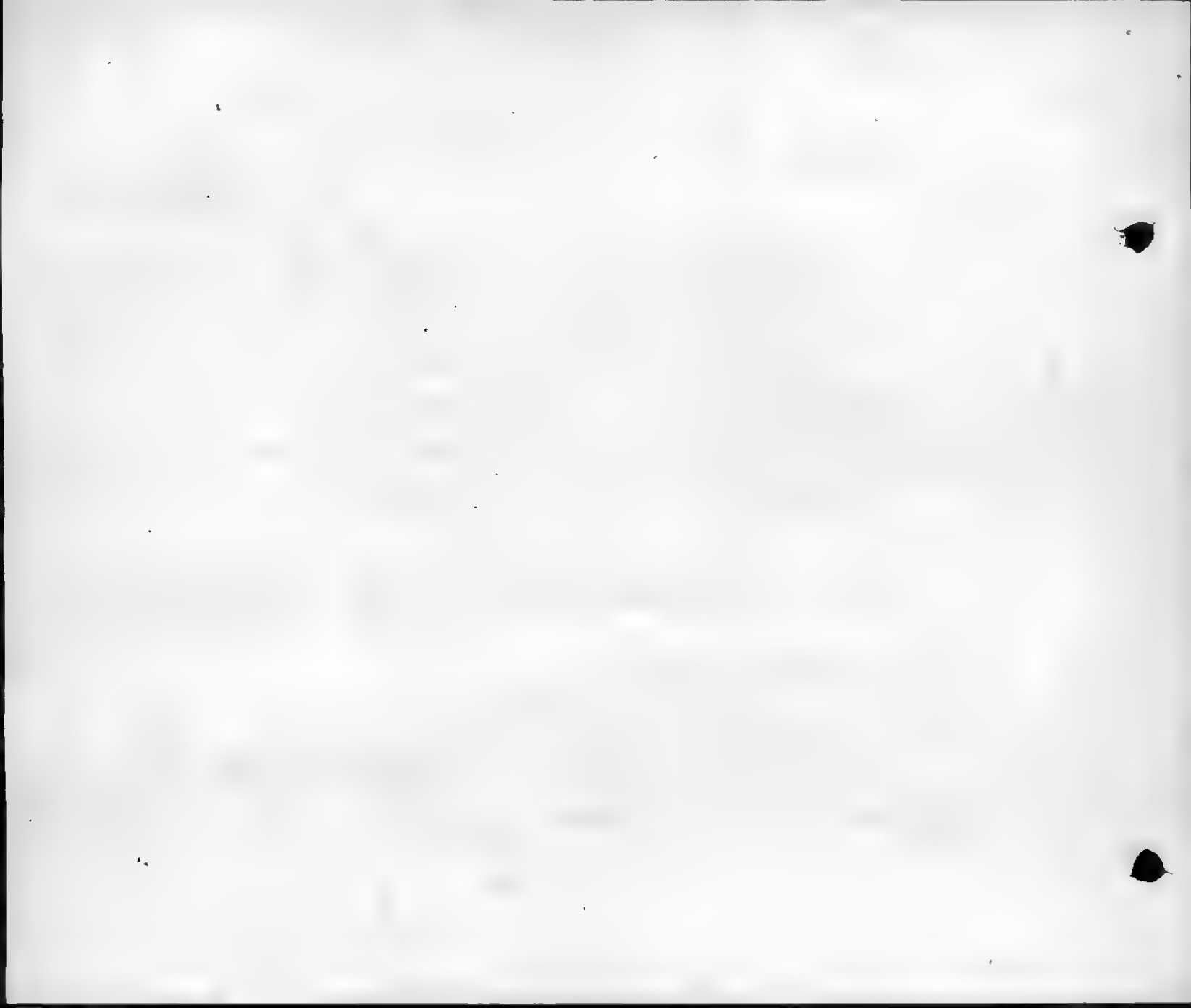


9731

STATE OF MARYLAND
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09702

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
c. LENGTH OF STAY IN 1b <u>18 DAYS</u>				d. STREET ADDRESS <u>407 West Main St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William</u> <u>EDWARD</u> <u>Collins</u>				4. DATE OF DEATH Month Day Year <u>August</u> <u>29</u> <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>NOV. 18, 1888</u>	
9. AGE (In years lost birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>			
13. FATHER'S NAME <u>WILLIAM E. COLLINS</u>				14. MOTHER'S MAIDEN NAME <u>SARAH A. COLBURN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>UNKNOWN</u>		17. INFORMANT Address <u>MRS ROY LESCEALLETT, POCOMOKE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic Staph pneumonia</u> <u>-41-1</u> DUE TO <u>and hemorrhagic shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bleeding duodenal ulcer</u> (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>12 days</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11 August, 1960</u> to <u>29 Aug. 1960</u> , that (I) (we) last saw the deceased alive on <u>28 Aug. 1960</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert E. Adkins</u> M.D.				22b. DATE SIGNED <u>29 Aug. 60</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT E. ADKINS</u>	
22d. ADDRESS <u>FRUITLAND, MARYLAND</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-31-60</u>		23c. NAME OF CEMETERY <u>NEWSON CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>RURAL-POCOMOKE, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u>				25a. REC'D BY REGISTRAR <u>POCOMOKE, MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>	



may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09703

9732

Item 11 Baltimore Health Department

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Somerset ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Route # 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leona Middle Cook Last Cook				4. DATE OF DEATH Month August Day 8 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1907	
9. AGE (In years last birthday) 53 yrs		IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min. 53		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unk.				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO -		17. INFORMANT Deer's Head State Hospital Records, Salisbury		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular dis., decompensated ? DUE TO (c) Arteriosclerosis, general ?						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Residual left hemiplegia due to cerebral thrombosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8:30 P.M. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 2, 1960 to August 8, 1960 , that (I) (we) last saw the deceased alive on August 8, 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE V. Juerman				22b. DATE 8/9/60		22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.	
22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kenna				25. REC'D BY REGISTRAR DATE AUG 18 '60		25b. REGISTRAR'S SIGNATURE	



9772

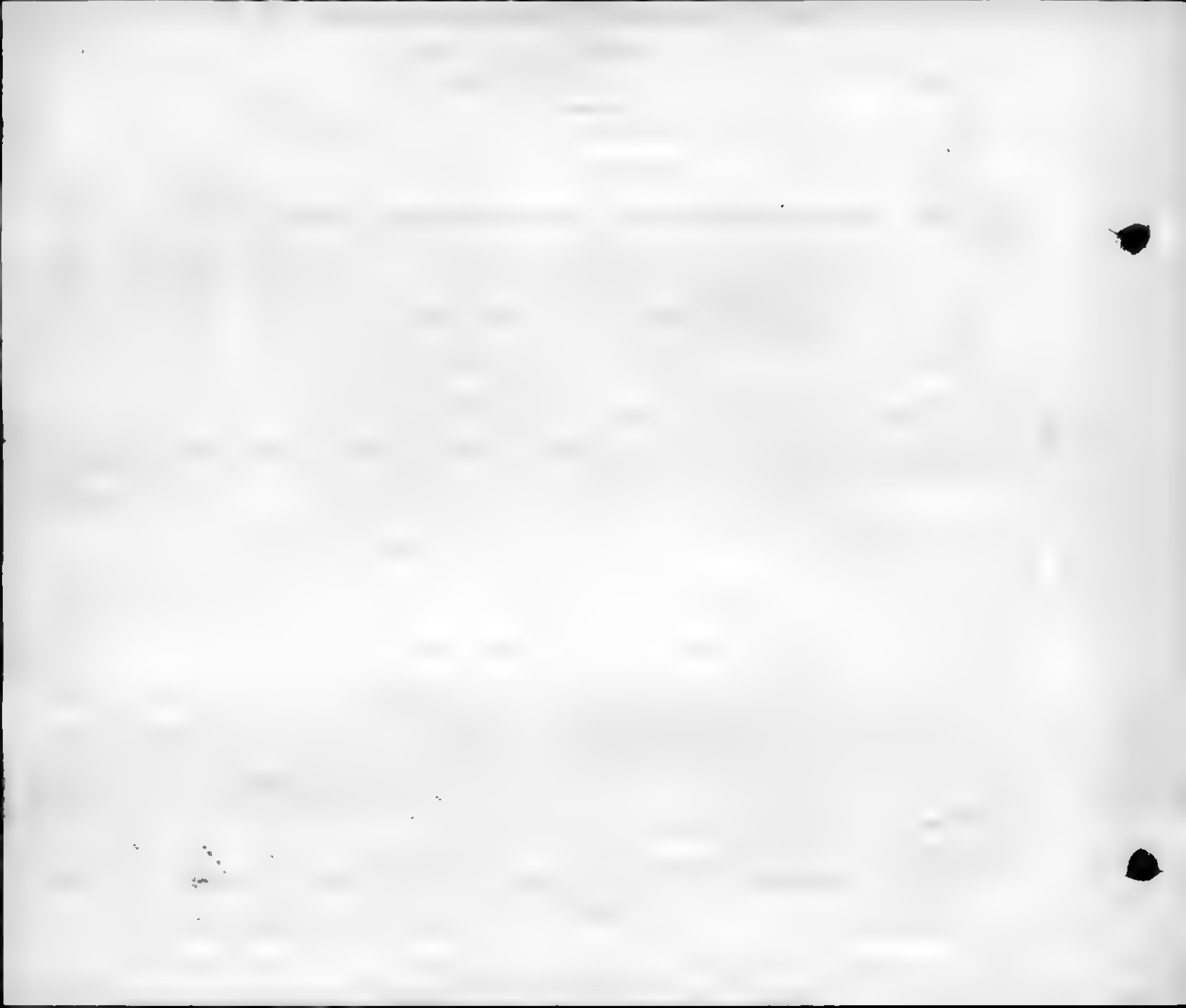
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs</u>		d. STREET ADDRESS <u>12612 FARNELL DR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPLE SHADE NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>WILSON</u> Last <u>CORNELL</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 13 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John W. Cook</u>		14. MOTHER'S MAIDEN NAME <u>Anna Coleman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MR ROWLEY CORNELL</u>		Address <u>12612 FARNELL DR. S.S. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy - Calcine</u> <u>53.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 8, 1957</u> , to <u>Aug 8, 1960</u> , that I last saw the deceased alive on <u>Aug 8, 1960</u> , and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. S. Kuhlman</u> M.D.		ADDRESS (Street, city or town, state) <u>Sharptown Md</u> DATE SIGNED <u>8/10/60</u>	
PHYSICIAN'S NAME (Type) <u>H. S. Kuhlman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug 11, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FIREMEN'S</u>		22d. LOCATION (City, town, or county) (State) <u>SHARPTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>SMITH FUNERAL HOME SHARPTOWN</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DATE AUG 15 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kears</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09705

9733

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>South Carolina</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW BERRY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Penninsula General Hospital</u>				d. STREET ADDRESS <u>7</u>			
3. NAME OF DECEASED (Type or print) <u>LESTER A. CROOKS</u>				4. DATE OF DEATH <u>August 27-1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6-4-1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vaughn Hood</u>				14. MOTHER'S MAIDEN NAME <u>Annie Hood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs. Jack Ayres, Newark, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> DUE TO <u>3 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>60</u> to <u>8/27</u> , 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>8/27</u> , 19 <u>60</u> , and that death occurred <u>9:10 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>	
22d. ADDRESS <u>Salisbury, Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-4-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. James Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Pomary, S.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley, Salisbury, Md.</u>				25a. REC'D BY REGISTRAR <u>DATE AUG 30 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William L. Hume</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

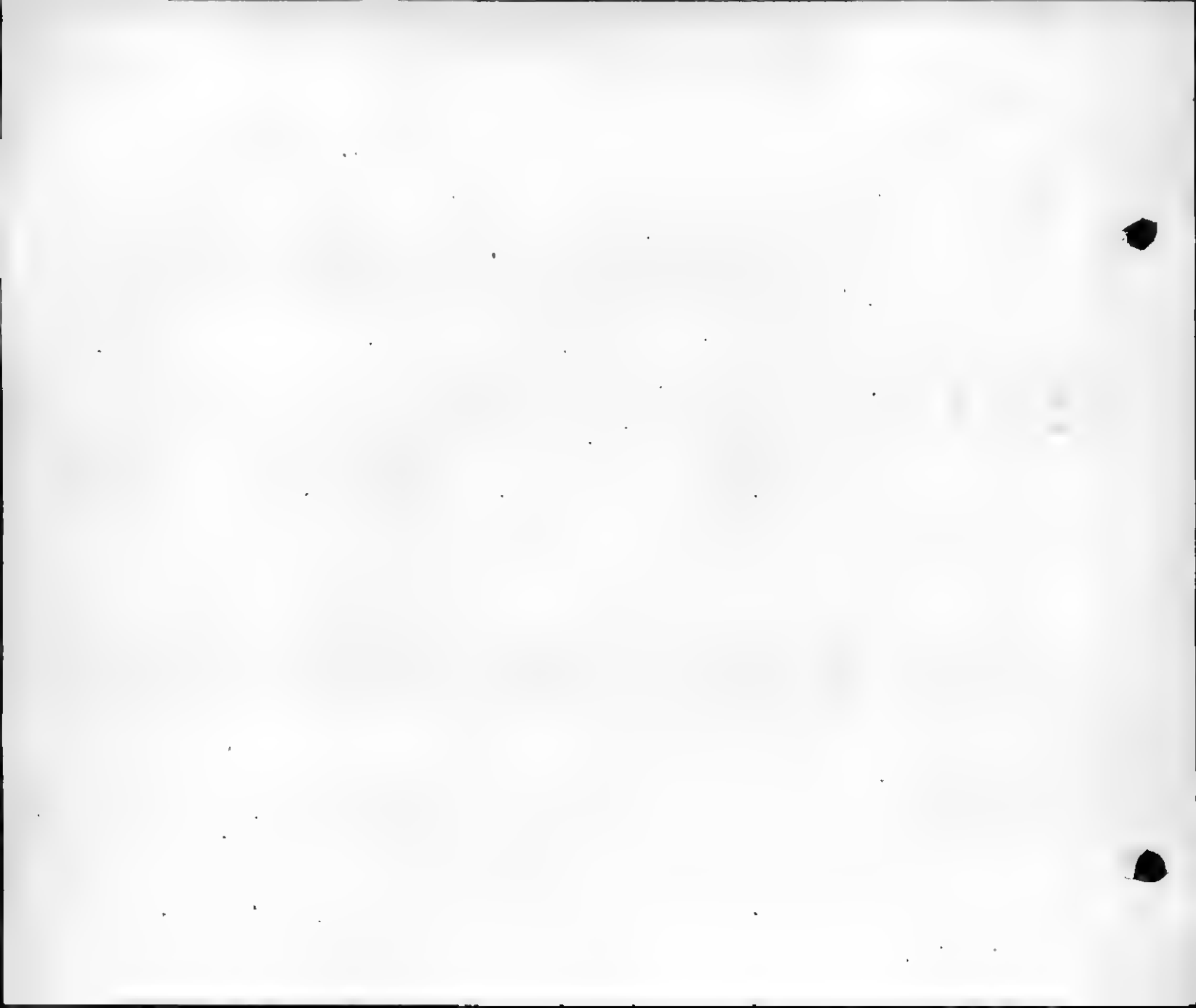
9774

CERTIFICATE OF DEATH

Reg. Dist. No. 09706

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>50 YRS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT #5</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> d. STREET ADDRESS <u>1 RT #5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LARRY</u> Middle <u>Jerome</u> Last <u>CULVER</u>		4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	11. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired General</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE GROLER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jerome F. Culver</u>		14. MOTHER'S MAIDEN NAME <u>MARY Nichols</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>214-36-5488</u>	
INFORMANT <u>MINNIE C. Culver</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>—</u> (b) <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/29</u> , 19 <u>59</u> , to <u>8/5</u> , 19 <u>60</u> that I last saw the deceased alive on <u>8/5</u> , 19 <u>60</u> , and that death occurred at <u>10:15</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u>		DATE SIGNED <u>8-6-60</u>	
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>		ADDRESS (Street, city or town, state) <u>SALISBURY, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-7-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co.</u>		24a. REC'D BY REGISTRAR <u>—</u>	
NAME <u>Norman F. Baker</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09707

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		e. STREET ADDRESS <u>300 Race St</u>	
3. NAME OF DECEASED (Type or print) <u>SARAH ELLEN DAWSON</u>		4. DATE OF DEATH <u>AUGUST 19, 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1896</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Garden S. Shockley</u>		14. MOTHER'S MAIDEN NAME <u>Ida Cranfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. Thomas J. Dawson (Husband)</u>		Address <u>300 Race St Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension & high cholesterol</u> DUE TO (c) <u>Chronic Diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>N/A</u> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>	20f. (City or town) <u>N/A</u> (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/12/60</u> 19 to <u>8/19/60</u> 19, that (I) (we) last saw the deceased alive on _____ 19, and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Dr. Carrie Hearn</u>		22b. DATE SIGNED <u>Aug. 20, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Carrie Hearn</u>		22d. ADDRESS <u>N. Division St. Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug. 22, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLOWAY & COMPANY</u>		25a. REGISTRAR'S SIGNATURE <u>Wm. S. Hearn</u>	
ADDRESS <u>SALISBURY MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. S. Hearn</u>	
25c. REC'D BY REGISTRAR <u>AUG 23 '60</u>		DATE	



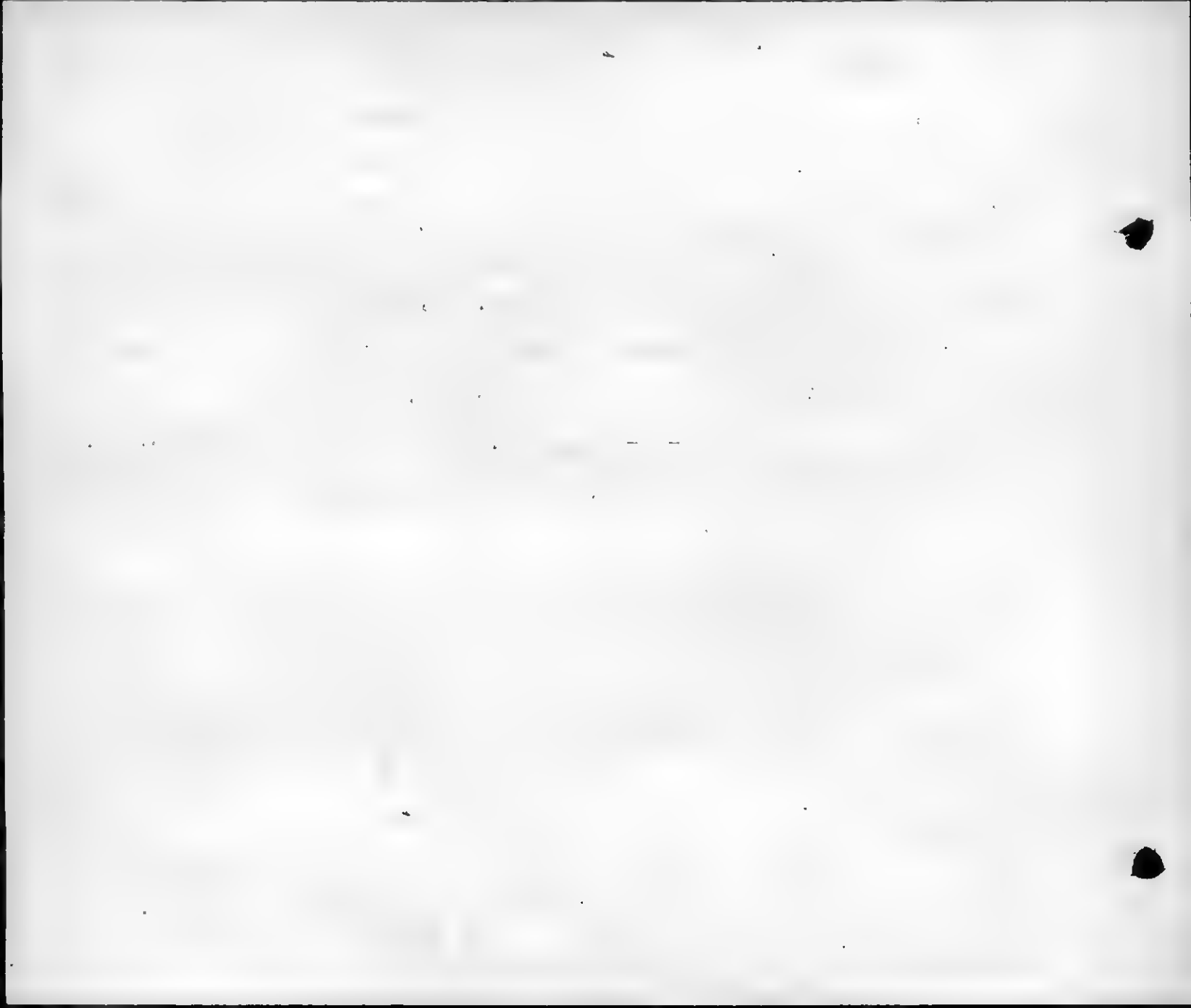
1

9735

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09798

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>Willards</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>1</u>				
3. NAME OF DECEASED (Type or print) First <u>Olive</u> Middle <u>Bell</u> Last <u>Dawnes</u>				4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1897</u>	9. AGE (In years lost birthday) yrs <u>62</u>	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shift Factory</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Machine Operator</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>George Baker</u>				14. MOTHER'S MAIDEN NAME <u>Ella B. Palmer</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>216-05-6591</u>		17. INFORMANT <u>Mrs. Aaron Wilkins</u> Address <u>Willards, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct, acute</u> DUE TO (b) <u>1 day</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <u>1 day</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A JPTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8-29-1960</u> to <u>8-29-1960</u> that (I) (we) lost the deceased olive on <u>8-29-1960</u> and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above								
22a. SIGNATURE <u>William B. Ewing</u> M.D.				22b. DATE SIGNED <u>8-29-60</u>		22c. PHYSICIAN'S NAME (Type)		
22d. ADDRESS				22e. REC'D BY REGISTRAR <u>SEP 6 '60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9-2-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>		23d. LOCATION (City, town, or county) (State) <u>Willards Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley</u>				25. REGISTRAR'S SIGNATURE <u>SEP 6 '60</u>				



9736

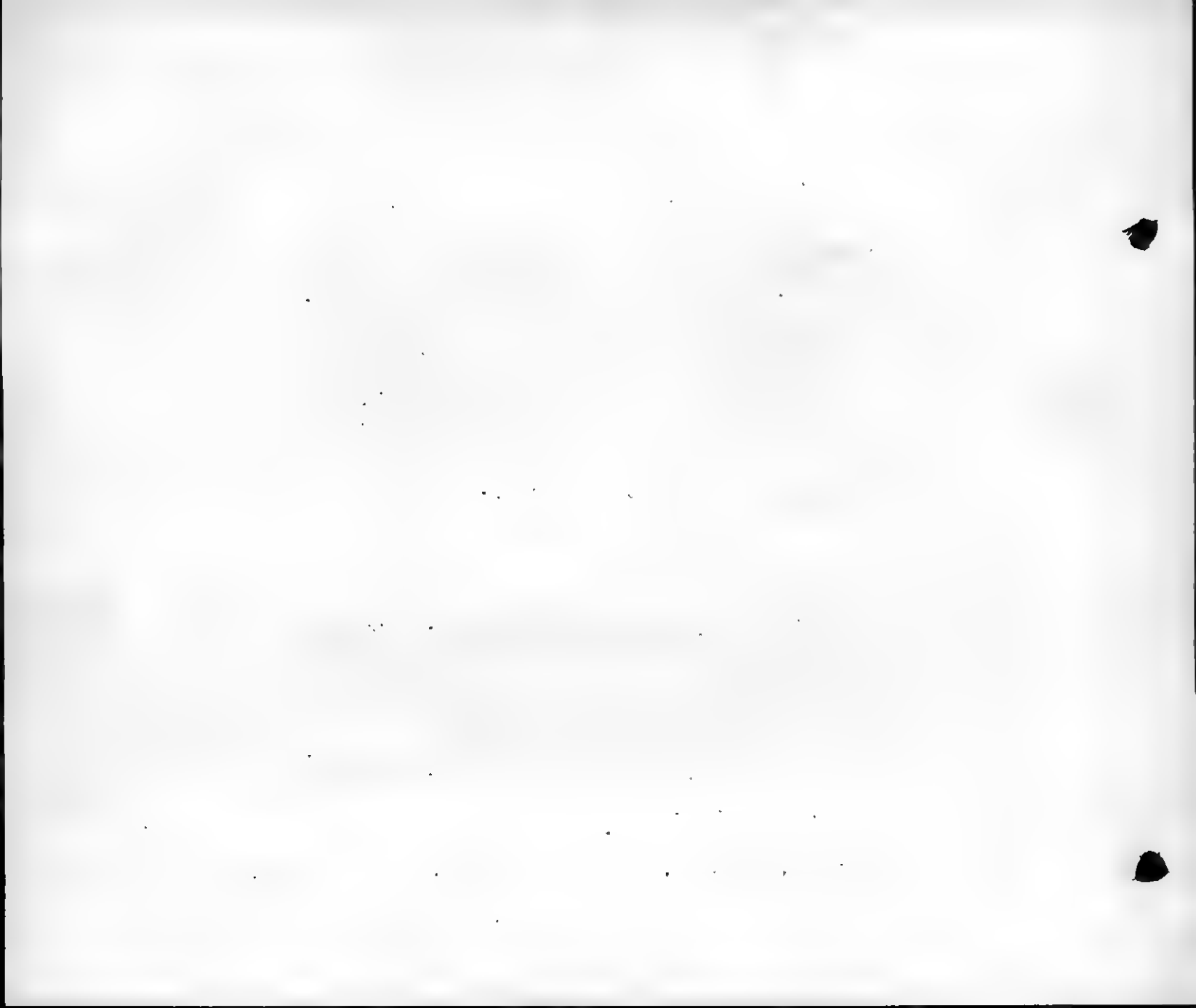
CERTIFICATE OF DEATH

Item 5 Film 208 8-8-60 et

Reg. Dist. No. 09709

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>5 YRS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 CAMDEN AVE EXT</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u> d. STREET ADDRESS <u>110 CAMDEN AVE EXT</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AMHERST</u> Middle <u>—</u> Last <u>EATON</u>		4. DATE OF DEATH Month <u>8</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Male</u> <u>White</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-1877</u> 9. AGE (In years last birthday) <u>82</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWS PAPER, RET EDITORIAL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EDITORIAL</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Eaton</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Washburn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>298-05-621</u> INFORMANT <u>Thomas C. Hill, Jr.</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Basal cell Carcinoma of Face + Neck</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December, 1954</u> , to <u>Aug 2, 1960</u> that I last saw the deceased alive on <u>August 2, 1960</u> , and that death occurred at <u>5:00</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Pine Bluff Road, Salisbury</u> DATE SIGNED <u>8/2/60</u>			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		DATE SIGNED <u>8/2/60</u>	
PHYSICIAN'S NAME (Type) <u>Thomas C. Hill, Jr.</u>		Pine Bluff Road, Salisbury	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-5-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Dale Cem</u>		22d. LOCATION (City, town, or county) (State) <u>URBANA, Ohio</u>	
23. BURIAL DIRECTOR'S SIGNATURE <u>Hill + Johnson Co. Salisbury, Md</u>		24a. REC'D BY REGISTRAR <u>AUG 4 '60</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9737

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09710

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>1 MONTH</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EWELL</u> d. STREET ADDRESS <u>17X-2</u>									
3. NAME OF DECEASED (Type or print) <u>MARY C. EVANS</u>			4. DATE OF DEATH Month <u>AUGUST</u> Day <u>27</u> Year <u>1962</u>										
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH <u>AUG. 15, 1882</u>		9. AGE (In years lost birthday) <u>78</u> yrs <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Months	Days	Hours	Min					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
Months	Days	Hours	Min										
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>BENJAMIN F. WHITNEY</u>			14. MOTHER'S MAIDEN NAME <u>KATHRYN EVANS</u>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. LEON EVANS - 24 MAIN ST. - CRISFIELD, MD.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Urinary Bladder</u> DUE TO <u>101.00</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>12 mon.</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>July 21, 1960</u> to <u>Aug. 26, 1960</u> that (I) first last saw the deceased alive on <u>Aug. 26, 1960</u>, and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Raymond M. Yow</u>		22b. DATE SIGNED <u>Aug. 27, 1960</u>		22c. PHYSICIAN'S NAME (Type) <u>RAYMOND M. YOW, M.D.</u>									
22d. ADDRESS <u>707 Camden Cere. Salisbury, Md.</u>													
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG. 30, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EWELL CEMETERY</u>									
23d. LOCATION (City, town, or county) <u>EWELL</u>		23e. (State) <u>MD.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>BRADSHAW & SONS.</u>			25a. REC'D BY REGISTRAR <u>CRISFIELD, MD.</u>										
25b. REGISTRAR'S SIGNATURE <u>Charles A. French</u>			25c. DATE <u>SEP 6 '60</u>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

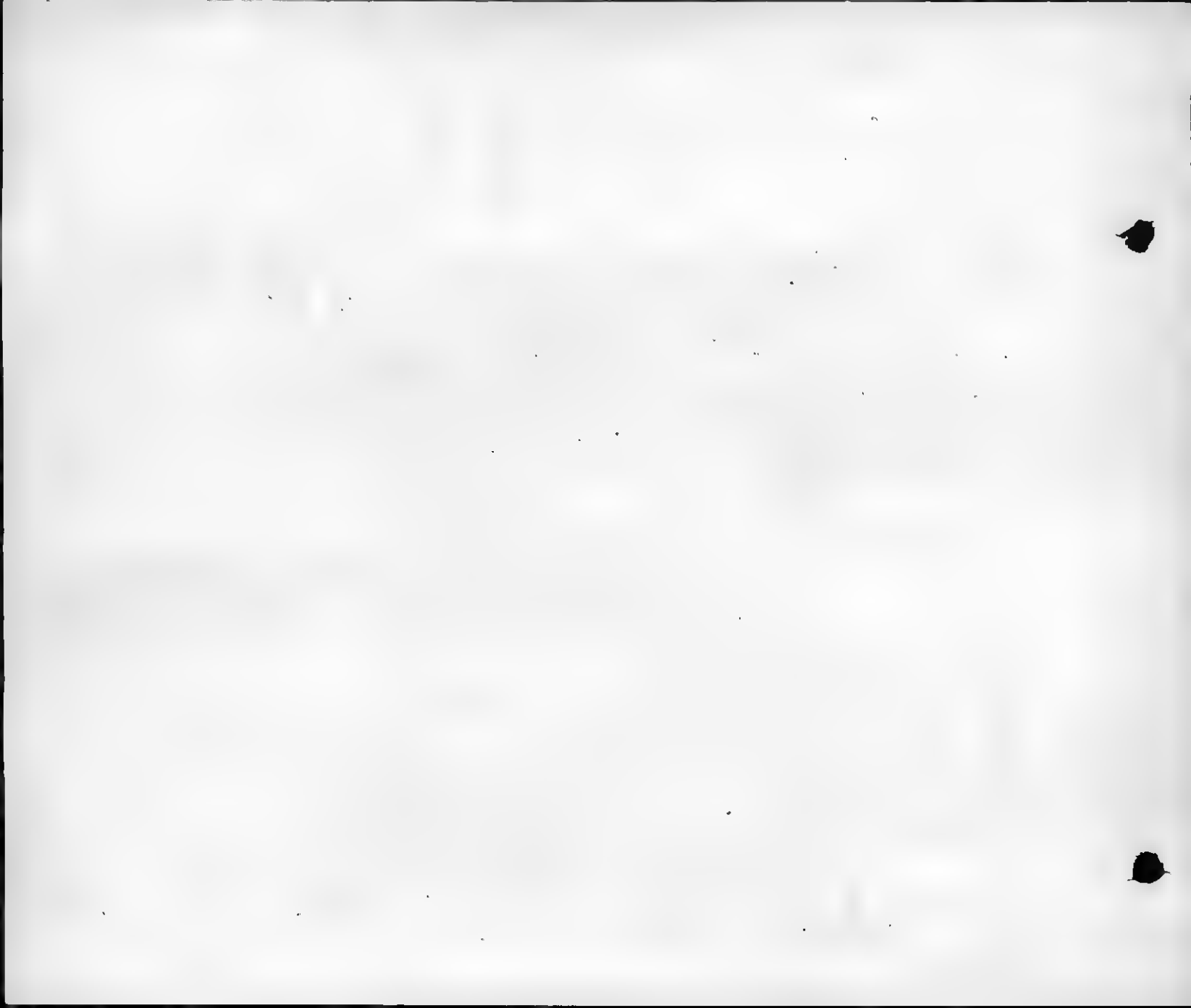


may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9738
CERTIFICATE OF DEATH

09711

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Salisbury</u> 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hosp.</u>				d. STREET ADDRESS <u>Cedar Way</u> 1			
3. NAME OF DECEASED (Type or print) <u>LILLIAN PARDEE Fields</u>				4. DATE OF DEATH <u>August 28</u> 19 <u>60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 29, 1905</u> 34 yrs	9. AGE (In years last birthday) <u>54</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing Mach. Oper.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SHIRT FACT.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ALEX W. CAREY</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE HASTINGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>214-10-7800</u>			
17. INFORMANT <u>Sidney Fields</u>				18. ADDRESS <u>Cedar Way Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1704</u> DUE TO <u>Bloma, terminal lobe,</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8-1</u> 19 <u>60</u> , to <u>8-28</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>8-28</u> 19 <u>60</u> , and that death occurred at <u>12:41</u> from the causes and on the date stated above							
22a. SIGNATURE <u>W. C. Ellis</u>				22b. DATE SIGNED <u>8-28-60</u>			
22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS <u>Salisbury, Maryland</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-31-1960</u>		23c. NAME OF CEMETERY <u>Methodist Washington Church Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomast. Waller</u>				25a. REC'D BY REGISTRAR <u>DATE AUG 30 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Carlton L. Kruza</u>							



TO HOST: 1. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

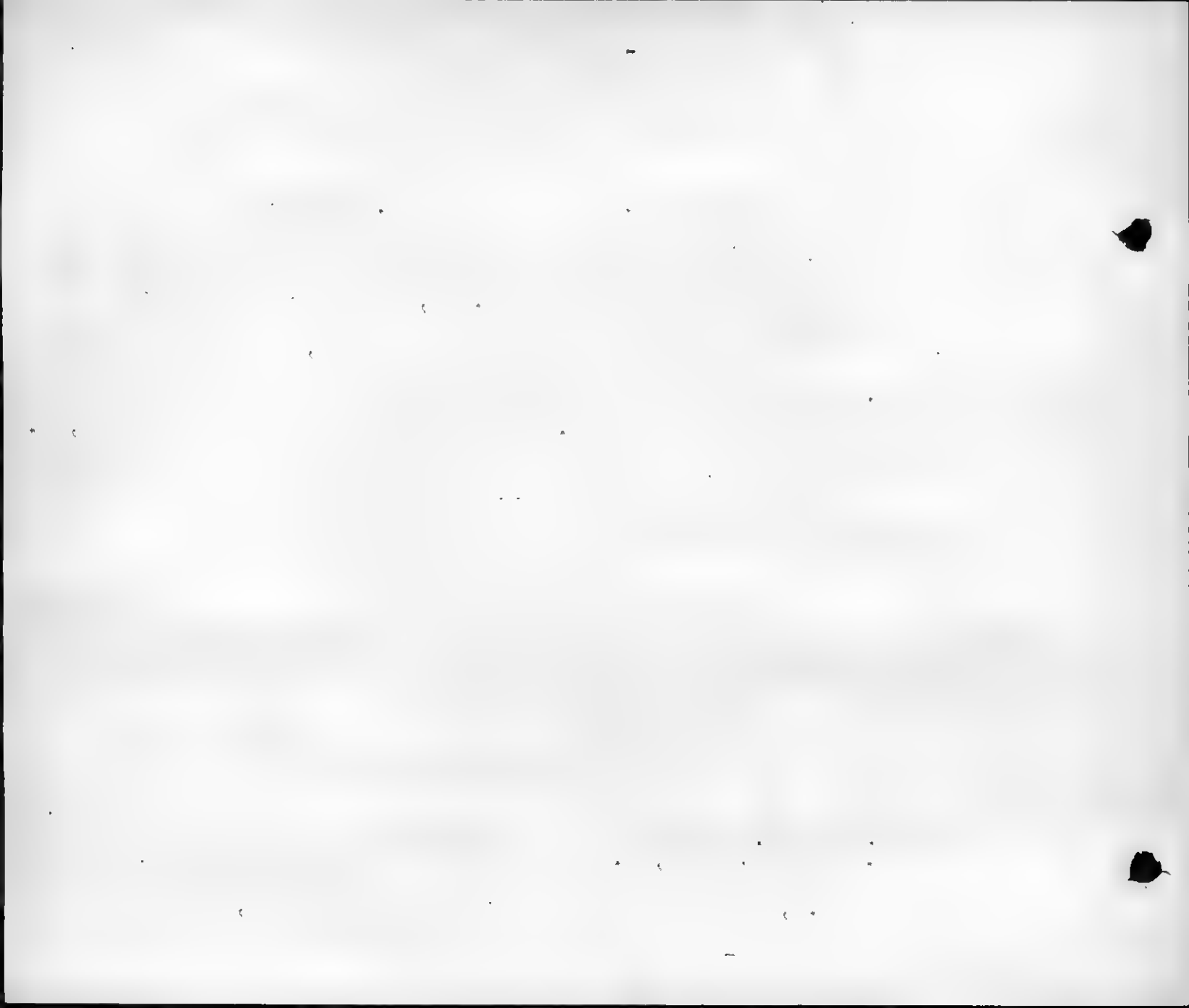
VR A15 (4)
ISM 9/59

CERTIFICATE OF DEATH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9739

09712

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 West Isabella St				d. STREET ADDRESS 108 W. Isabella St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLEN DALE (McMASTER) FISHER				4. DATE OF DEATH Month AUGUST Day 5th Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 22, 1880	
9. AGE (in years last birthday) 79 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		11. BIRTHPLACE (State or foreign country) Princess Anne, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William S. McMaster				14. MOTHER'S MAIDEN NAME Ella Dale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. E. McMaster Duer (Nephew)		17. INFORMANT Address Princess Anne, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	
20f. (City or town) N/A				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 5, 1958 to August 5, 1960 that (I) (we) last saw the deceased alive on 8-2-60 and that death occurred at 1:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Dr. David J. Gilmore 22c. PHYSICIAN NAME (Type) Dr. Wilber R. Ellis, Jr.				22b. DATE SIGNED August 5, 1960 22d. ADDRESS Medical Center - Salisbury, Maryland			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 7, 1960		23c. NAME OF CEMETERY OR CREMATORY Manokin Cemetery - Princess Anne, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND				25a. REC'D BY REGISTRAR DATE AUG 8 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon between pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

9740

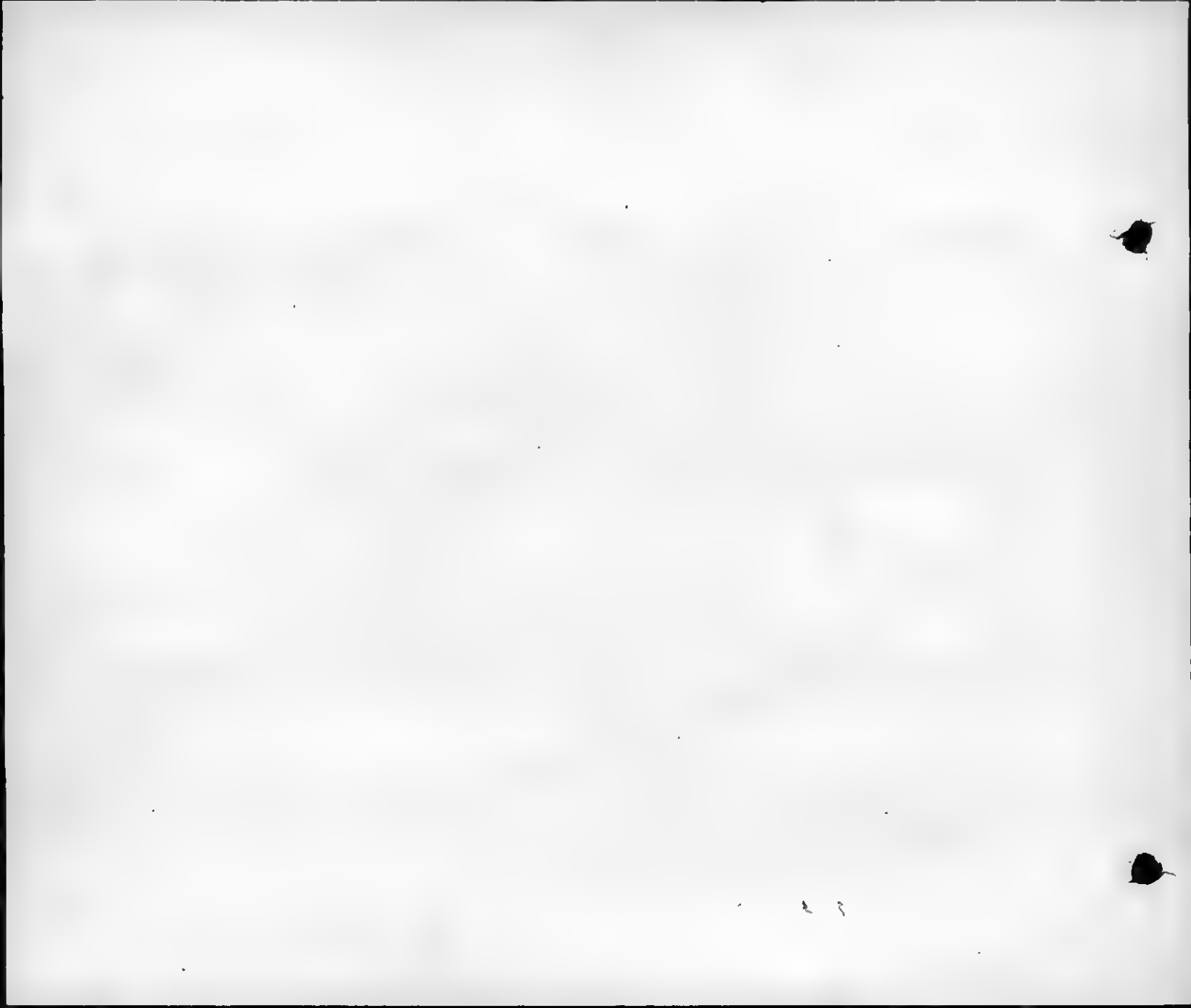
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 filed 7/9-15-60 et

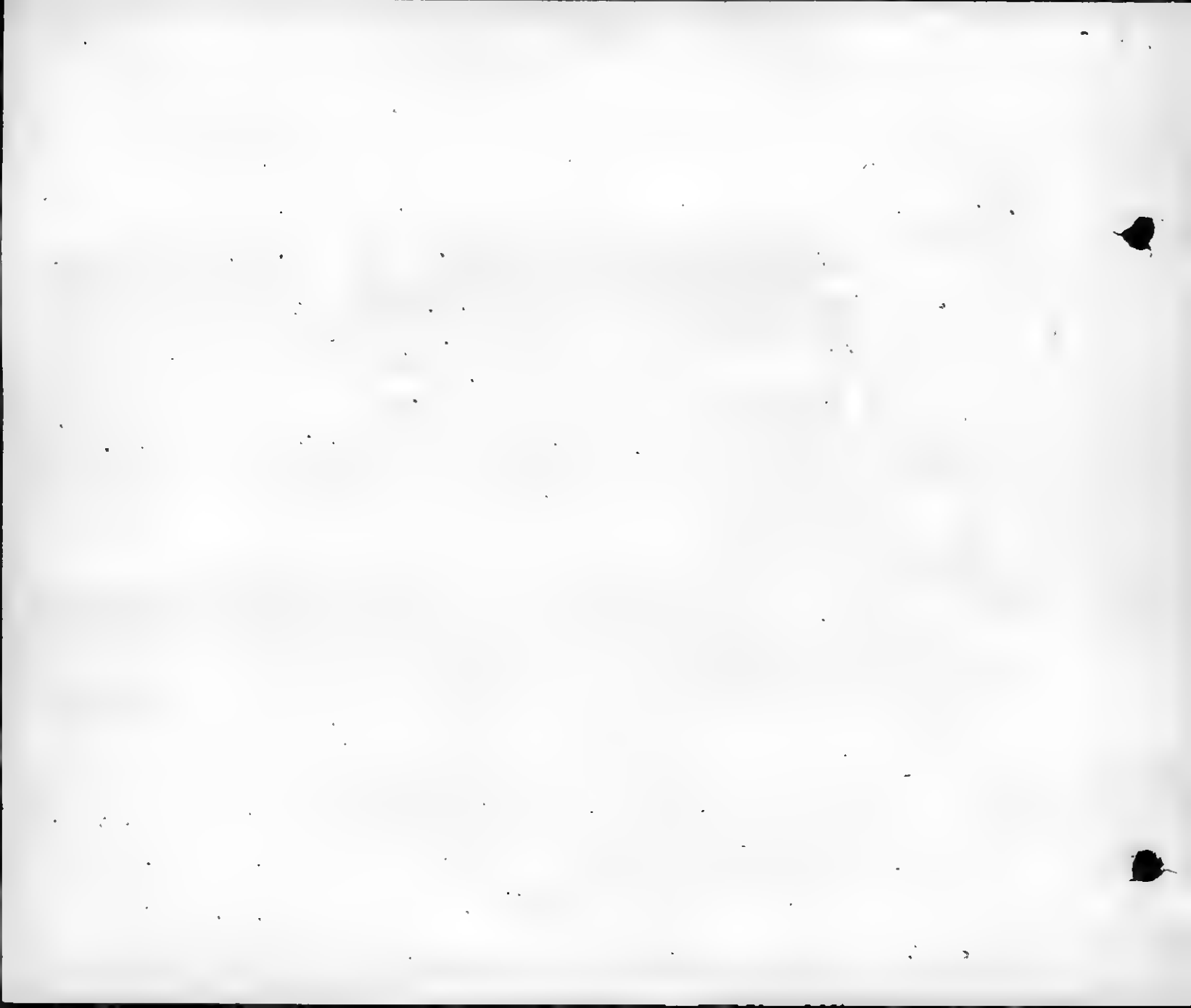
09713

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>RFD --</u>			
3. NAME OF DECEASED (Type or print) <u>Lo Roy W. Fisher</u>				4. DATE OF DEATH <u>August 29-1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 30, 1917</u>	9. AGE (If years lost birthday) <u>42</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIL CARRIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK FISHER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET LUILEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WORLD WAR II</u>		16. SOCIAL SECURITY NO <u>No</u>		17. INFORMANT <u>Mrs. L.W. FISHER</u> Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Thrombosis</u> <u>570.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-27</u> , 19 <u>60</u> , to <u>8-29</u> , 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>8-29</u> , 19 <u>60</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William E. Ellis</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-29-60</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/31/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anne A. Burbage</u> ADDRESS <u>Berlin Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 1 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	



MEDICAL CERTIFICATION

VS A15 (4)
15M 9/58



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9742

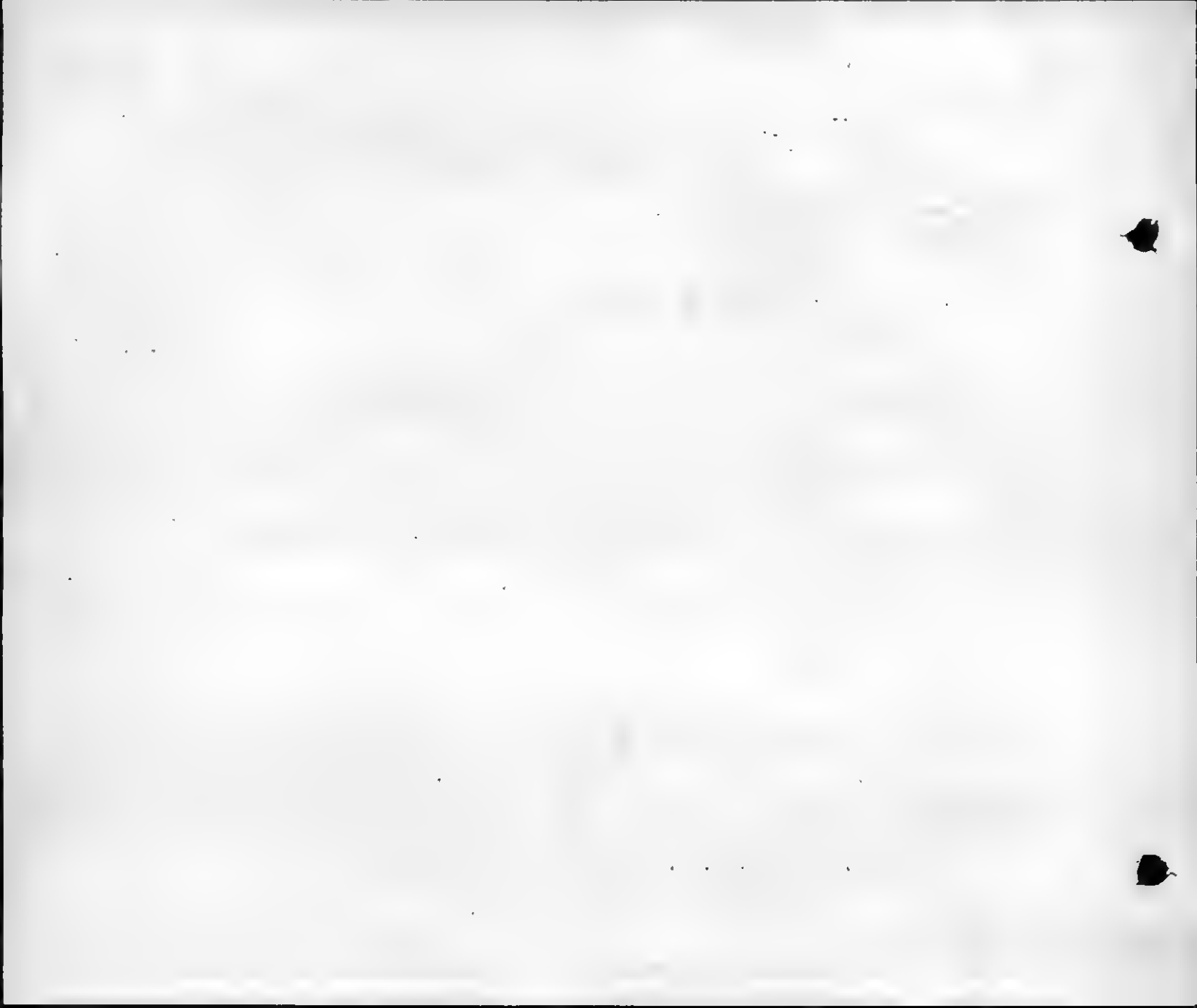
CERTIFICATE OF DEATH

Reg. Dist. No. 09715

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 73 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. STREET ADDRESS 617 Pearl Street	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HARMON Last HARMON		4. DATE OF DEATH Month August Day 22 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Harmon		14. MOTHER'S MAIDEN NAME Mary Dutton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Ethel Quillen, 617 Pearl St., Salisbury, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus		INTERVAL BETWEEN ONSET AND DEATH 2 minutes	
DUE TO (b) Arteriosclerotic cardiovascular disease		Years	
DUE TO (c) Arteriosclerosis, general		Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 20 , 19 60 , to August 22 , 19 60 , that I last saw the deceased alive on Aug. 22 , 19 60 , and that death occurred at 8:45 A.M. , from the causes and on the date stated above			
ACTUAL SIGNATURE V. Juerman		DATE SIGNED 8/22/60	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Deer's Head State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 25, 1960	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Fruitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart, Salisbury, Md.		24a. REC'D BY REGISTRAR AUG 26 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Walter S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9743

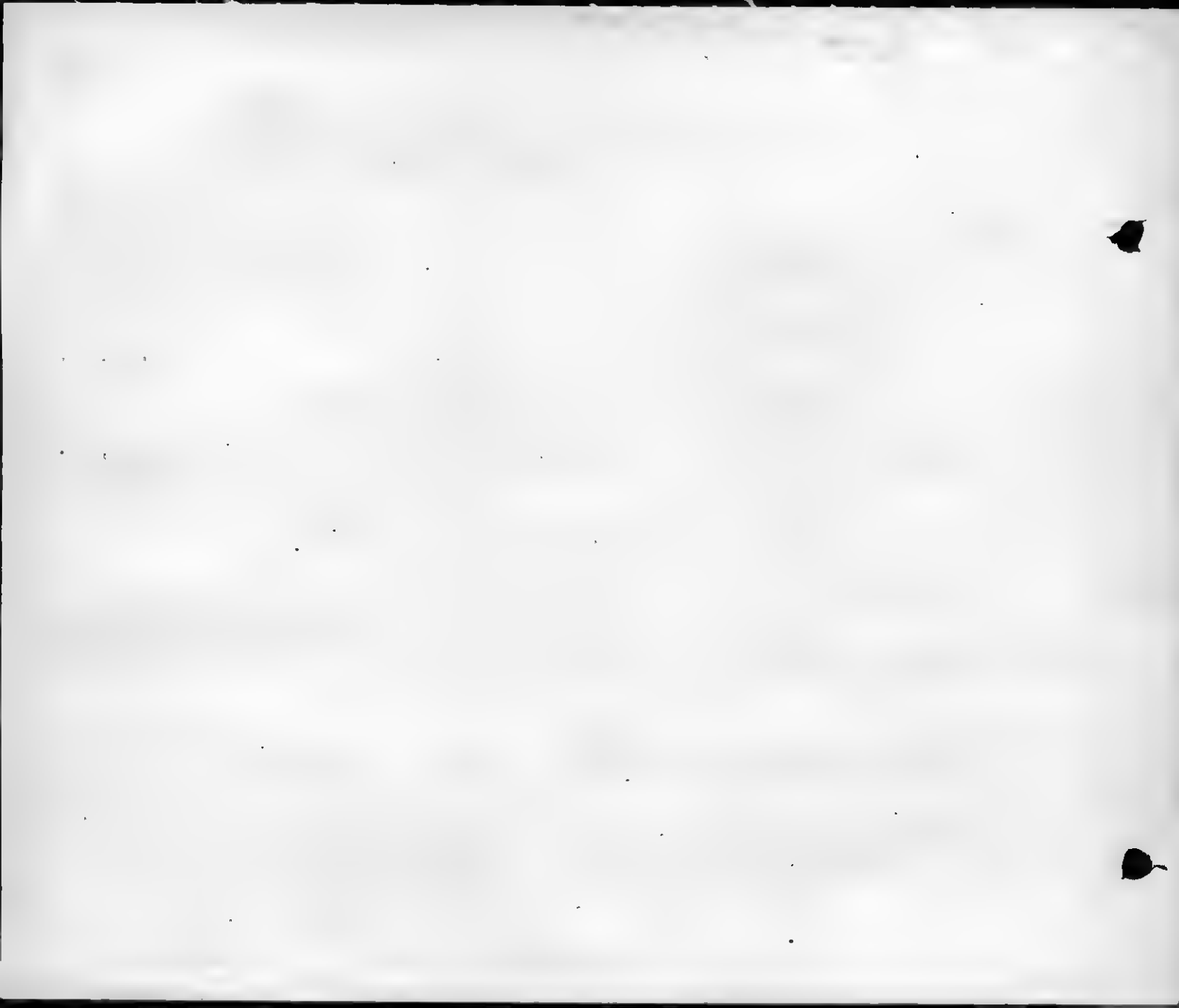
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09715

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE <u>Virginia</u> c. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural New Church</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Augustine</u> Middle <u>Hernandez</u> Last <u>Hernandez</u>				4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/5/60</u>	9. AGE (In years last birthday) yrs	10. UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Pablo Hernandez</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Hernandez</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Pablo Hernandez</u> Address <u>New Church, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Intermittent Pneumonia</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> 1960, to <u>8/10</u> 1960, that (I) (we) last saw the deceased alive on <u>8/10</u> 1960, and that death occurred at <u>12:30</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>William C. Morgan</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>8/10/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Morgan</u>				22d. ADDRESS <u>Salisbury Md</u>			
23a. BURIAL, CREMATON, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/11/60</u>		<u>Downings Cemetery</u>		<u>Oak Hall, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>For Funeral Home,</u>				ADDRESS <u>Temperanceville, VA</u>		25a. REC'D BY REGISTRAR <u>AUG 15 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

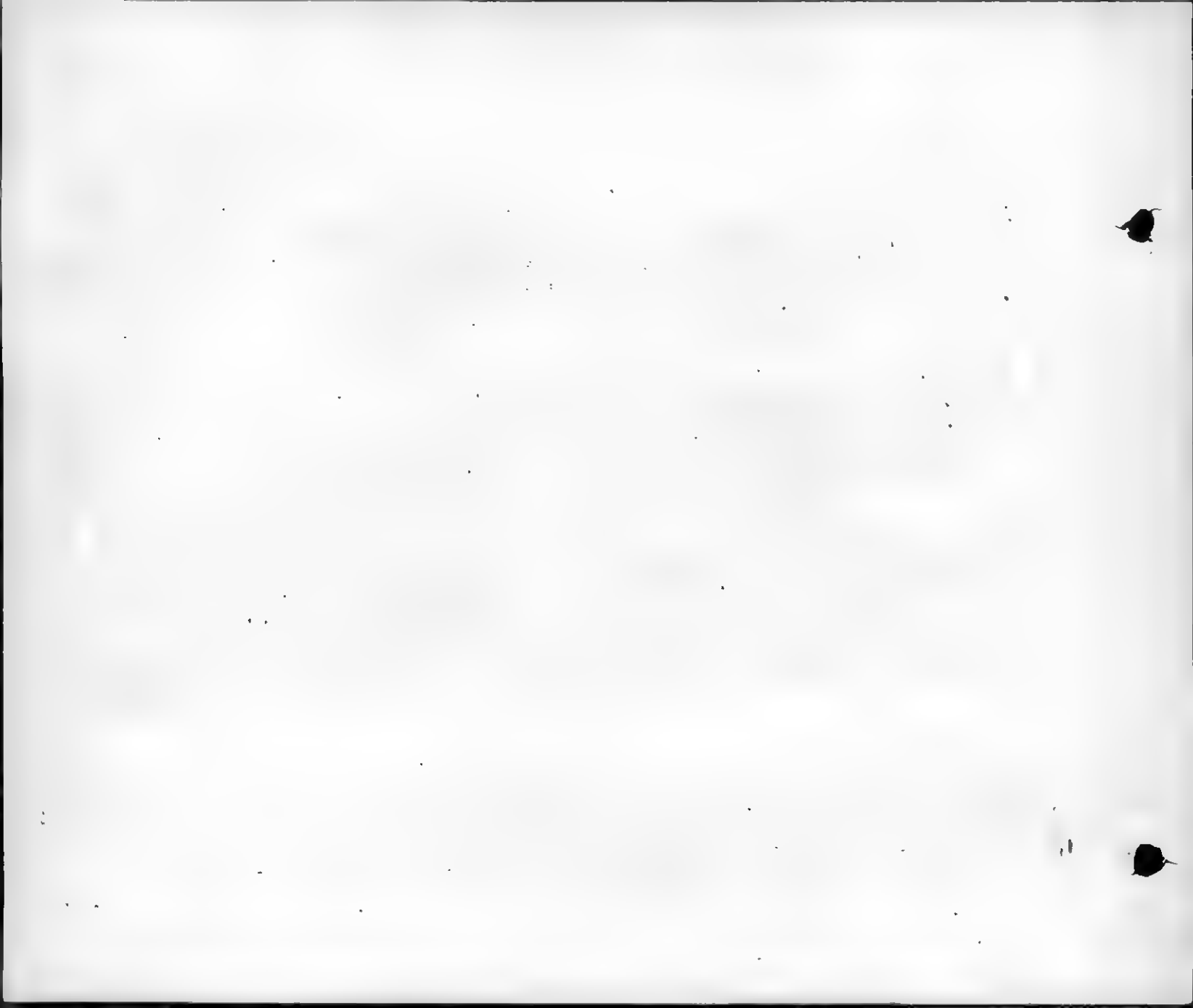
Reg. Dist. No. 09718

9744

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>		d. STREET ADDRESS <u>Chestnut Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Johnson</u>				4. DATE OF DEATH Month Day Year <u>August 3 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 3, 1960</u>		9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Lillia Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. ADDRESS <u>B. Johnson Hebron Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>760.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perinatal Hypoxia</u> DUE TO (c) <u>Prematurity & Ruptured Marginal Sinus and Antenatal Bleeding</u>							INTERVAL BETWEEN ONSET AND DEATH <u>approx 17 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/3</u> , 19 <u>60</u> , to <u>8/3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/3</u> , 19 <u>60</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred P. Kolls</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center Salisbury Maryland</u>					
PHYSICIAN'S NAME (Type) <u>Salisbury Maryland</u>		DATE SIGNED <u>8/3/60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-9-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glass Hill Cn</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dorothy M. West</u>				ADDRESS <u>Salisbury Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 12 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>William S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9745

CERTIFICATE OF DEATH

09719

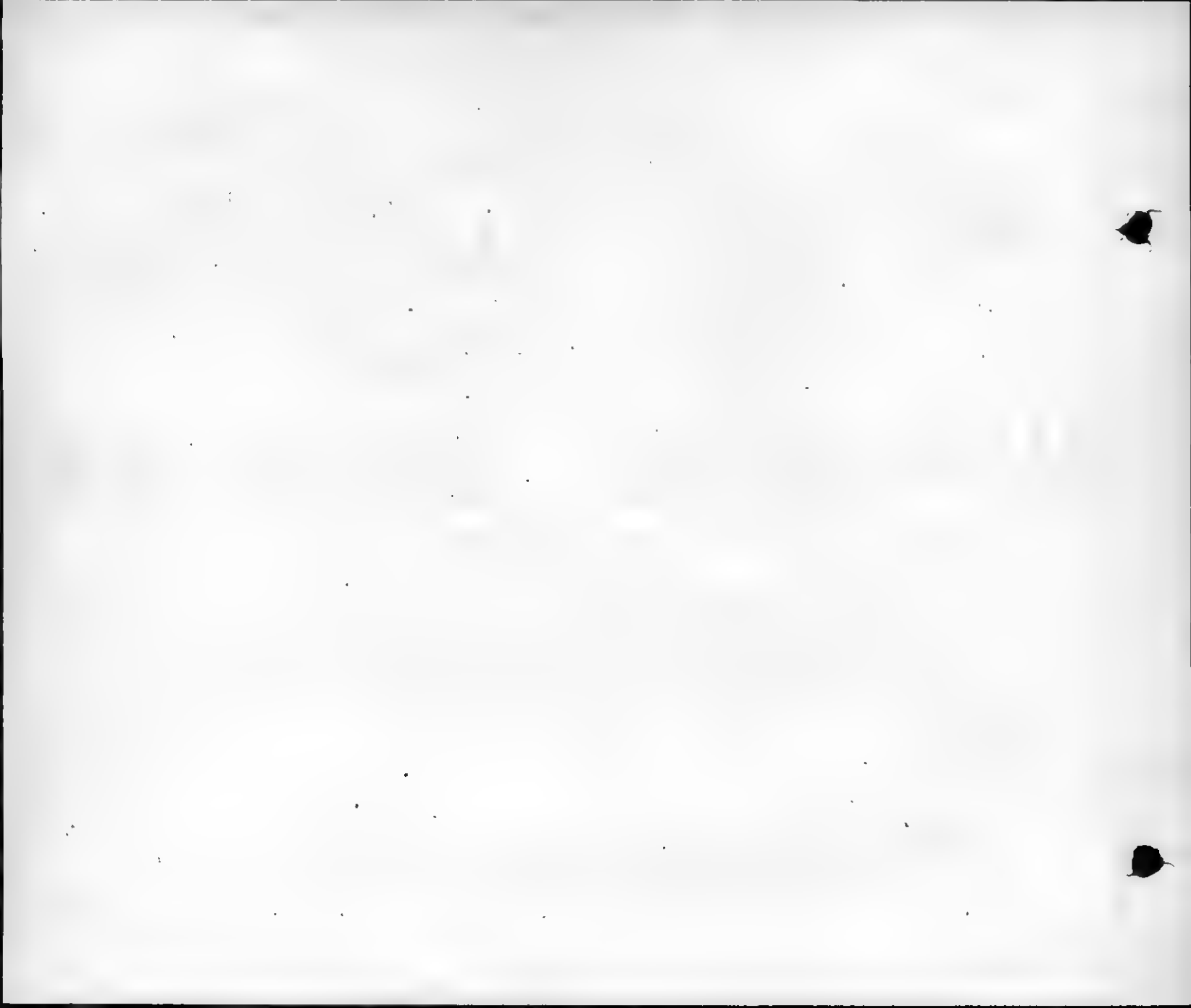
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 HR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		g. STREET ADDRESS <u>1107 Ashlyn Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Josiah Woolford Johnson</u>		4. DATE OF DEATH Month Day Year <u>August 8 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>CONTRACTOR & Designer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Josiah Johnson</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA Humphreys</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>216-16-7525</u>	
17. INFORMANT <u>Mrs J. W. Johnson, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis, Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Coronary Sclerosis</u> DUE TO <u>?</u> (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 Aug</u> , 19 <u>60</u> , to <u>8 Aug</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8 August</u> , 19 <u>60</u> , and that death occurred at <u>3:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert Adkins</u> M.D.		ADDRESS (Street, city or town, state) <u>FRUITLAND, MARYLAND</u> DATE SIGNED <u>8 Aug 60</u>	
PHYSICIAN'S NAME (Type) <u>Robert Adkins</u>		<u>FRUITLAND, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-10-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, MD</u>		24a. REC'D BY REGISTRAR <u>AUG 10 '60</u>	
ADDRESS <u>Norman T. Baker:</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



9746

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Accomack</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Hamrook</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prancock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springhill Sanatorium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Susie Warren Johnson</u>		4. DATE OF DEATH Month Day Year <u>8 29 1960</u>	
5. SEX <u>Fr</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 23, 1882</u>
9. AGE (In years lost b rthday) <u>77 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>8 1 2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ringoteague</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John L. Warren</u>		14. MOTHER'S MAIDEN NAME <u>Sarah T. Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Virginia Bureau</u>	
17. INFORMANT <u>Parkley, Va</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.10</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-15</u> , 19 <u>60</u> , to <u>8-29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-27</u> , 19 <u>60</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>W B Ellis, Jr</u> M.D. <u>Salisbury, Md.</u>		<u>8-27-60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/31/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Edgemoor</u>		22d. LOCATION (City, town, or county) (State) <u>Accomack Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Richard Johnson</u>		24a. REC'D BY REGISTRAR <u>SEP 2 '60</u>	
ADDRESS <u>Parkley, Va</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9747

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>105 CHESTNUT</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR W. LECATES</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 9 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	
11 BIRTHPLACE (State or foreign country) <u>DELMAR</u>		12 CITIZEN OF WHAT COUNTRY? <u>UNIT</u>	
3. FATHER'S NAME <u>JOHN LECATES</u>		14. MOTHER'S MAIDEN NAME <u>ALICE CALLAWAY</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW I</u>		16 SOCIAL SECURITY NO <u>716-03-60</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Pyelonephritis & Renal Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>600.00</u> (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obstructive Emphysema with Polycythemia</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 6, 1960</u> to <u>August 9, 1960</u> that I last saw the deceased alive on <u>August 9, 1960</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C Hill Jr.</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Prine Bluff Rd. 8/9/60</u> <u>Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-11-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>DELMAR - DE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marrel Co - Delmar, Del</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 11 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

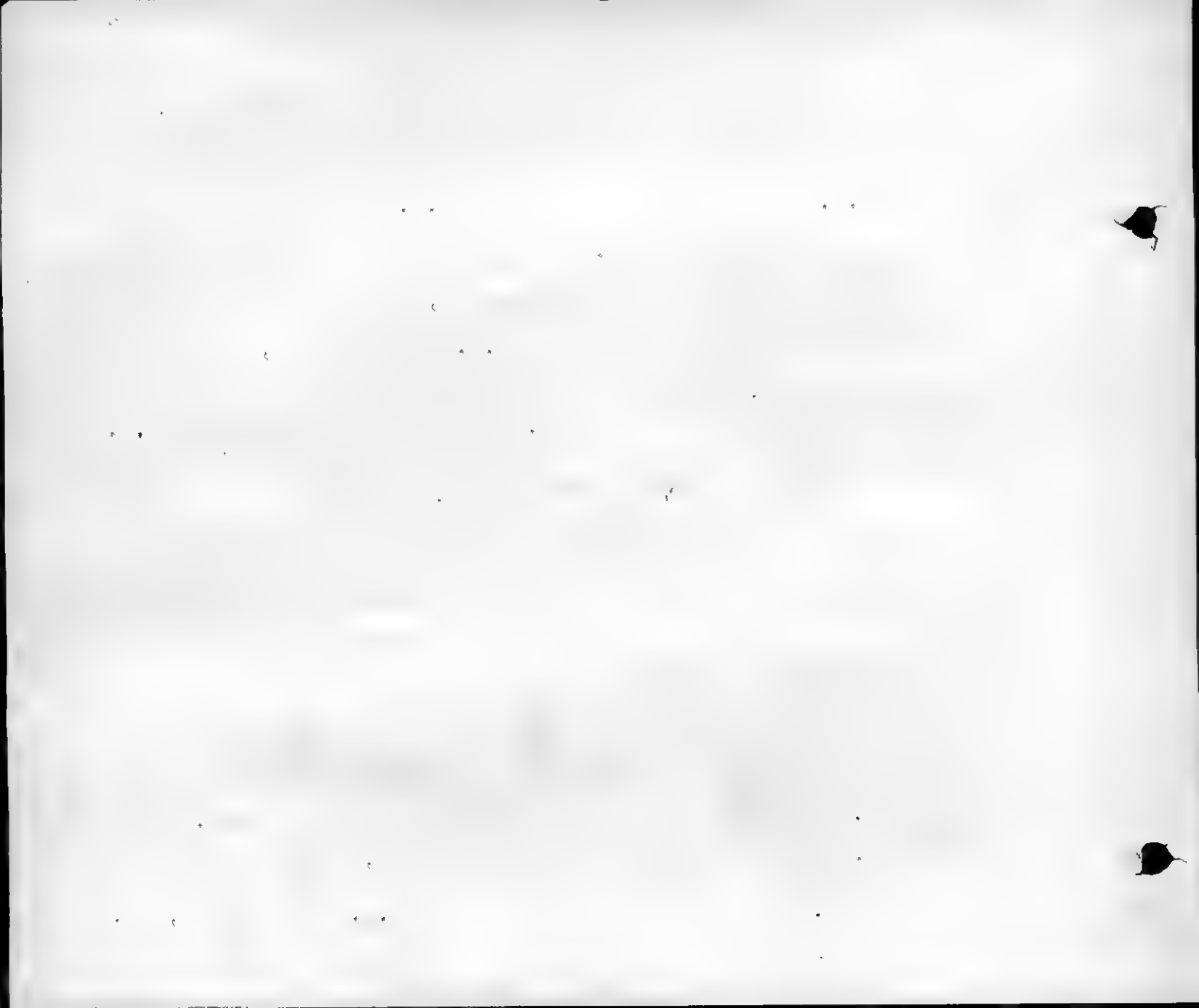
VR A15 (4)
ISM 9/59

9775

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09722

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1				e. STREET ADDRESS R.D.# 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEE Middle R. Last LIVINGSTON				4. DATE OF DEATH Month AUGUST Day 16th Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1877	
9. AGE (In years last birthday) 83 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) R.D.# 1 Salisbury, Md	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Benjamin Peter Livingston		14. MOTHER'S MAIDEN NAME Martha Carey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Maurice Holloway (Daughter) R.D.# 1 (St Luke Rd) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial degeneration DUE TO generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c) ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	
20f. (City or town) N/A				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from January 1960 to August 1960 , that (I) (we) last saw the deceased alive on 12 August 1960 , and that death occurred 100% M, from the causes and on the date stated above.							
22a. SIGNATURE Dr. Robert Adkins				22b. DATE SIGNED Aug. 18 / 1960		22c. PHYSICIAN'S NAME (Type) Dr. Robert Adkins	
22d. ADDRESS Fruitland, Maryland				22e. ADDRESS Fruitland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 18 / 1960		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town, or county) (State) R.D.# Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR AUG 22 '60	
25b. REG-STRAR'S SIGNATURE Arthur S. Kraus				25c. REG-STRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH-AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09723

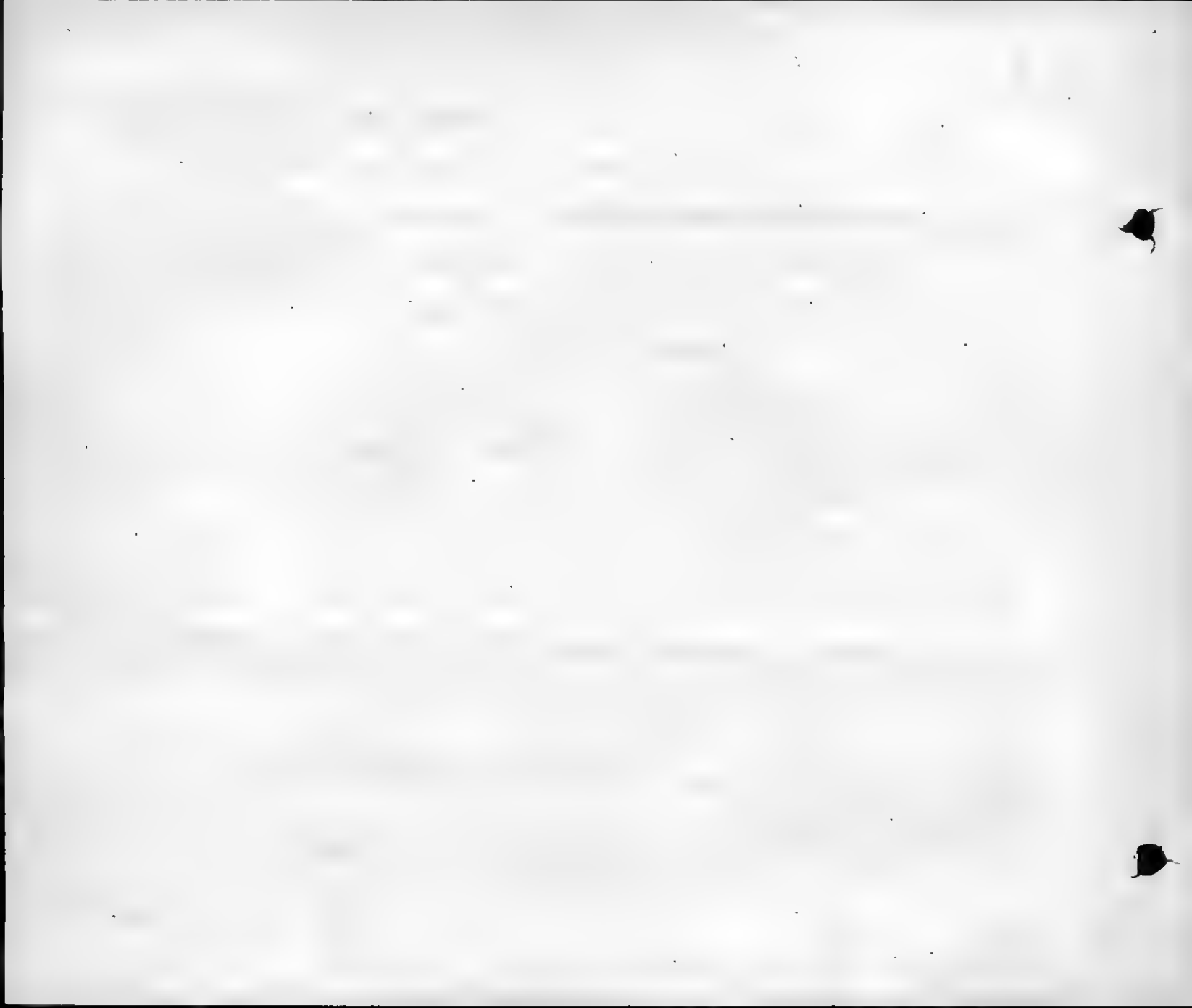
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonsbury (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LENIASIA GENERAL HOSPITAL</u>				e. STREET ADDRESS <u>R.D.# 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET WHITAKER McCullough</u>				4. DATE OF DEATH Month Day Year <u>August 18 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 16, 1896</u>		9. AGE (in years lost birthday) <u>64</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor - Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Joseph J. Lawrence</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Dixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT Address <u>Dr. Kendrick McCullough (Husband) R.D.# 1 Parsonsbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung</u>							<u>2 yrs.</u>
1831 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic obstructive heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>N/A 19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>	
				20f. (City or town) <u>N/A</u>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 18 1960</u> to <u>Aug. 18 1960</u> , that (I) (we) lost saw the deceased alive on <u>Aug. 18 1960</u> and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u>				22b. DATE SIGNED <u>Aug. 18, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore</u>				22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug. 24 /1960</u>		<u>South View Cemetery</u>		<u>Randolph, Vermont</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HOLLOWAY & COMPANY SALISBURY MARYLAND</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 22 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



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 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

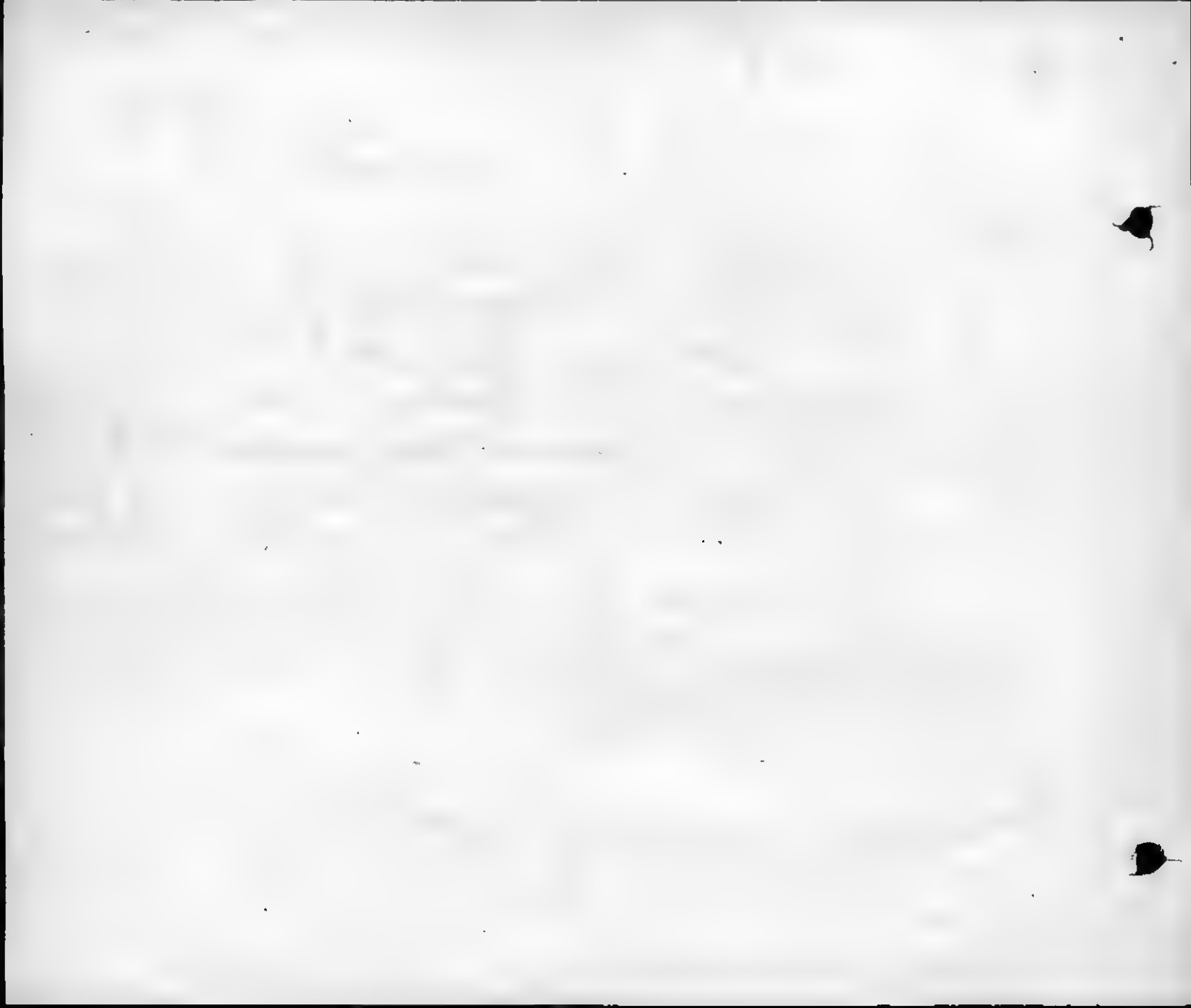
09724

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY Accomack ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - NEW CHURCH			
c. LENGTH OF STAY IN 1b 9 DAYS				d. STREET ADDRESS —			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES PAIGE miles				4. DATE OF DEATH Month Day Year August 11 - 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 29, 1887 72 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WESLEY S. MILES				14. MOTHER'S MAIDEN NAME ANNIE TAYLOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 231-46-3100		17. INFORMANT Address VERNON W. MILES, HORSEY, VIRGINIA			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Unkilled carcinoma of colon 153-8 DUE TO (b) Carcinoma of left colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 2 yrs				INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from Aug 2 - 1960 to Aug 11 - 1960 that (I) (we) last saw the deceased alive on 8-11-1960 and that death occurred at 11:30 M. from the causes and on the date stated above.							
22a. SIGNATURE H. A. Briele				22b. DATE SIGNED 8-11-60		22c. PHYSICIAN'S NAME (Type) H. A. Briele	
				22d. ADDRESS Medical Center			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-14-60		23c. NAME OF CEMETERY OR CREMATORY NELSON CEMETERY		23d. LOCATION (City, town, or county) (State) RURAL - Pocomoke City, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson				25a. REC'D BY REGISTRAR Pocomoke City, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
				DATE AUG 16 '60			



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9750
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
69725

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
c. LENGTH OF STAY IN 1b <u>37 weeks</u>				d. STREET ADDRESS <u>231</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>L.</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25-1886</u>	9. AGE (In years, last birthday) <u>73 1/4</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min <u>11</u>		IF UNDER 24 HRS Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Richardsville, md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>md</u>				13. FATHER'S NAME <u>Sidney Lewis</u>			
14. MOTHER'S MARDEN NAME <u>Sallie M. Tibbitt</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>216-09-8046</u>				17. INFORMANT <u>M. Thornton J. Mills, Snow Hill, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>525X</u> DUE TO <u>Branchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Fibrosis + Emphysema</u> DUE TO <u>Stenosis</u> (c) <u>Stenosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> Hour <u>19</u> o. m. <u>19</u> p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7/24 80 5/11</u>			
20f. (City or town) <u>1960</u>				20g. (County) <u>1960</u>			
20h. (State) <u>1960</u>				20i. (State) <u>1960</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>7/24 80</u> to <u>5/11 60</u> , that (I) (we) last saw the deceased alive on <u>5/11 60</u> , and that death occurred at <u>7</u> AM, from the causes and on the date stated above							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>8/12/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				22d. ADDRESS <u>Medical Center, Salisbury, Md.</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial Aug 14/60</u>				23b. DATE THEREOF <u>Aug 14/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Whitcomb Cemetery</u>				23d. LOCATION (City, town or county) <u>Snow Hill</u>			
23e. (State) <u>md</u>				23f. (State) <u>md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				25a. REC'D BY REGISTRAR <u>Aug 15 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>				25c. (State) <u>md</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9751

09726

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Res. dence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BISHOPS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>35 X -</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>F.</u> Last <u>MURRAY</u>				4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 11 - 1905</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>VAN MURRAY</u>			
14. MOTHER'S MAIDEN NAME <u>NAN ESHAM</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>220-12-0437</u>				17. INFORMANT <u>MRS LILA MURRAY</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of Aortic Aneurysm</u> 4-1X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 min.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>15 Aug. 1960</u> to <u>18 Aug. 1960</u> , that (I) (we) last saw the deceased alive on <u>18 Aug. 1960</u> , and that death occurred at <u>4:15</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/20/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH C. FITZGERALD</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/21/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>		23d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Burbage</u>				ADDRESS <u>Baltimore Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 25 '60</u>	
25b. REG. STRAR'S SIGNATURE <u>John L. Kline</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

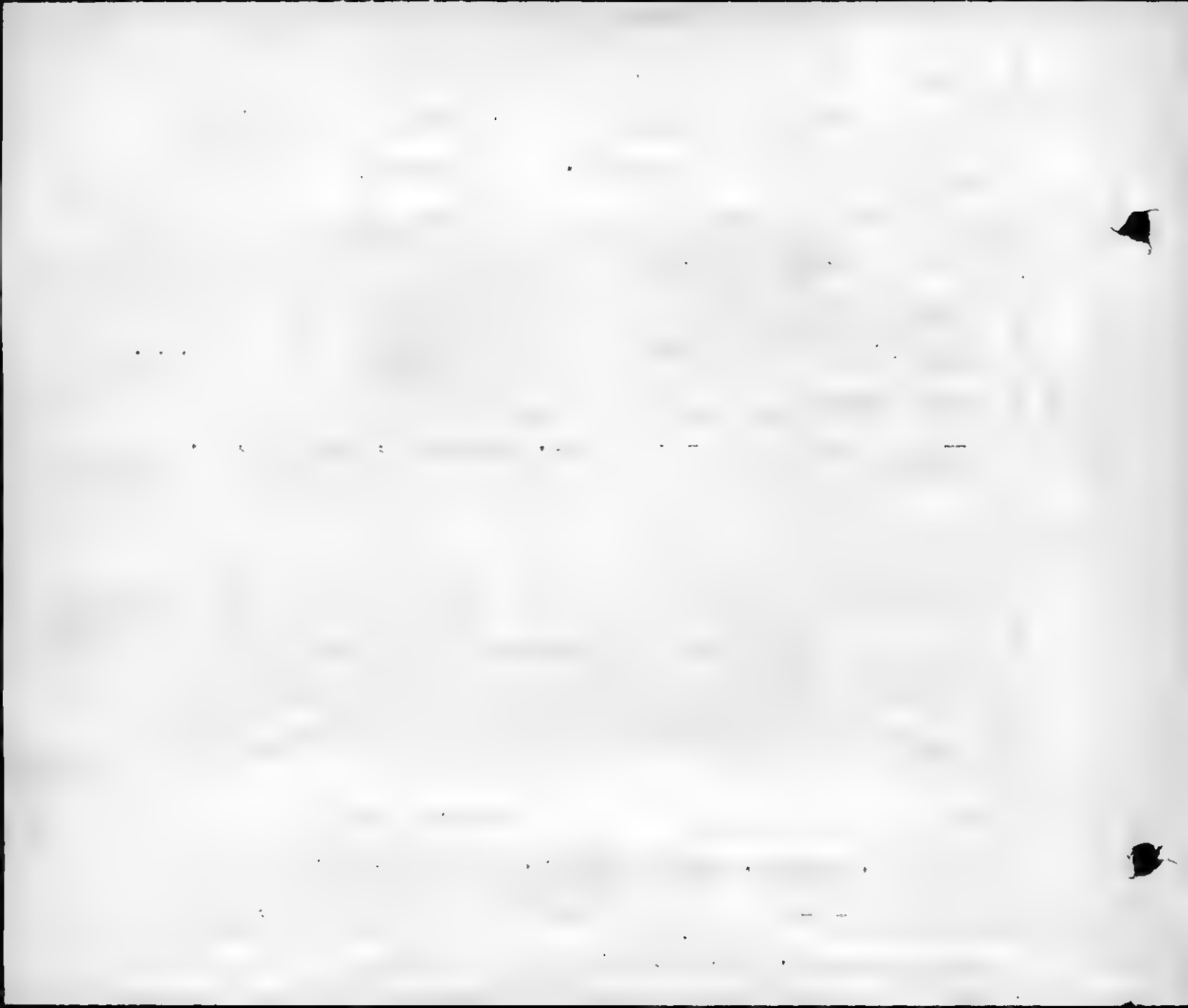
9776

CERTIFICATE OF DEATH

Reg. Dist. No.

09727

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsburg		c. LENGTH OF STAY IN 1b 10 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RHODA Middle MITCHELL Last PARSONS		4. DATE OF DEATH Month 8 Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR: Months 3 Days 20 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sharp Mitchell		14. MOTHER'S MAIDEN NAME Nettie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] None		16. SOCIAL SECURITY NO. 217-14-8260	
17. INFORMANT Mr. Ben Parsons, Parsonsbug, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 DUE TO arteriosclerotic Heart Disease with failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) bronchitis		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 9 a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/24 , 19 56 , to 8/9 , 19 60 , that I last saw the deceased alive on 8/1 , 19 60 , and that death occurred at 4:00 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest M. Larmore		ADDRESS (Street, city or town, state) Delmar, Delaware	
PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore		DATE SIGNED 8-11-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-12-1960	
22c. NAME OF CEMETERY OR CREMATORY Farlow's Cemetery		22d. LOCATION (City, town, or county) (State) Pittsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co.		ADDRESS Salisbury, Maryland	
24a. REC'D BY REGISTRAR AUG 12 '60		24b. REGISTRAR'S SIGNATURE Clay S. Kline	

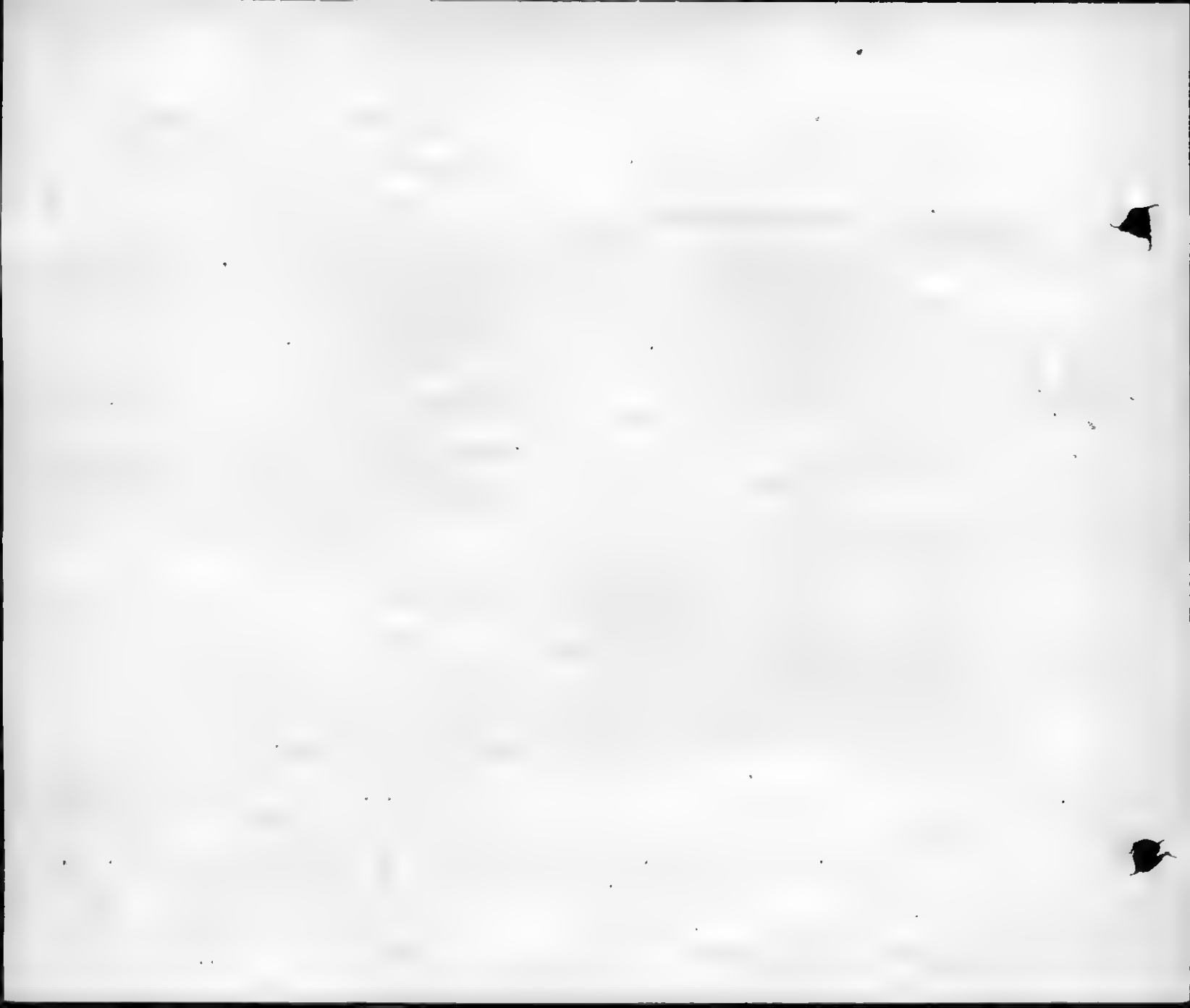


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CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09728

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 118 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 174		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Paul Last Paul				4. DATE OF DEATH Month Aug. Day 22 Year 19 60			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-21-36	
9. AGE (In years last birthday) 24 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor		11. BIRTHPLACE (State or foreign country) Jacksonville Fla U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ullmer				14. MOTHER'S MAIDEN NAME Fannie Patricia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Deer's Head Hosp.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized sarcomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from April 26 1960 to August 22 1960 , that (I) (we) last saw the deceased alive on Aug. 22 1960 , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE V. Juerman				22b. DATE SIGNED 8/22/60		22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.	
				22d. ADDRESS Deer's Head Hospital; Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-60		23c. NAME OF CEMETERY OR CREMATORIUM Green Wood Cem		23d. LOCATION (City, town, or county) (State) Jacksonville Fla	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks & Co. Salisbury				25a. REC'D BY REGISTRAR Aug 31 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

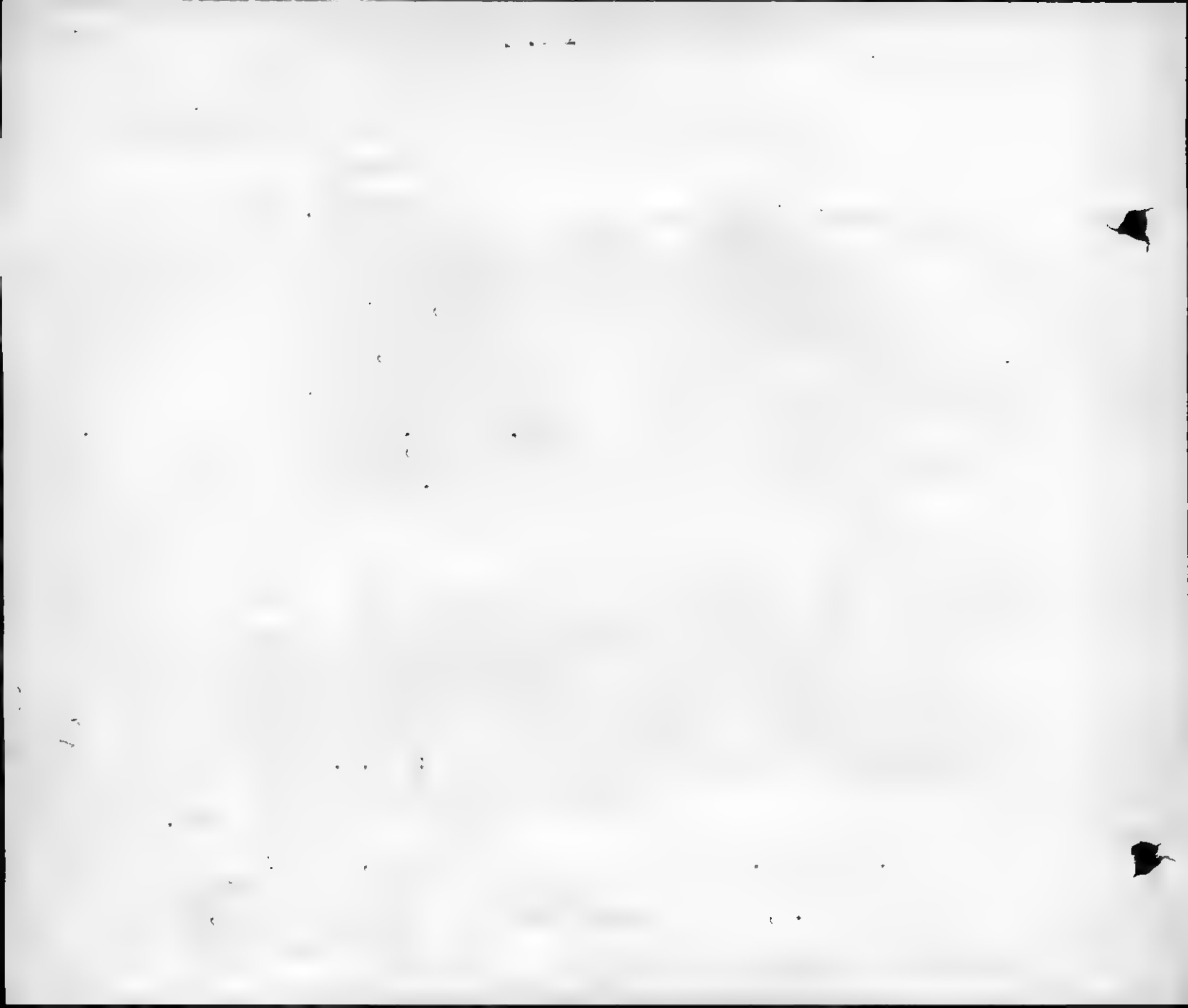


may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09729

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hosp				d. STREET ADDRESS Camden Ave. Ext			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle DAVID Last PETITT				4. DATE OF DEATH Month AUGUST Day 29th Year 1960			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1874		9. AGE (In years last birthday) 86 yrs	IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Snow Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David Petitt				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 216-40-3654		17. INFORMANT Mrs. Edna M. Petitt (Wife) Address Camden Ave. Ext Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate & metastases DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 2 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 11 July 1960 to 29 August 1960 , that (I) (we) last saw the deceased alive on 29 August 1960 , and that death occurred at 6:10 P.M. M., from the causes and on the date stated above							
22a. SIGNATURE Robert T. Adkins				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Aug. 30/1960	
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins				22d. ADDRESS Fruitland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 1, 1960		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR SEP 1 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			



CERTIFICATE OF DEATH

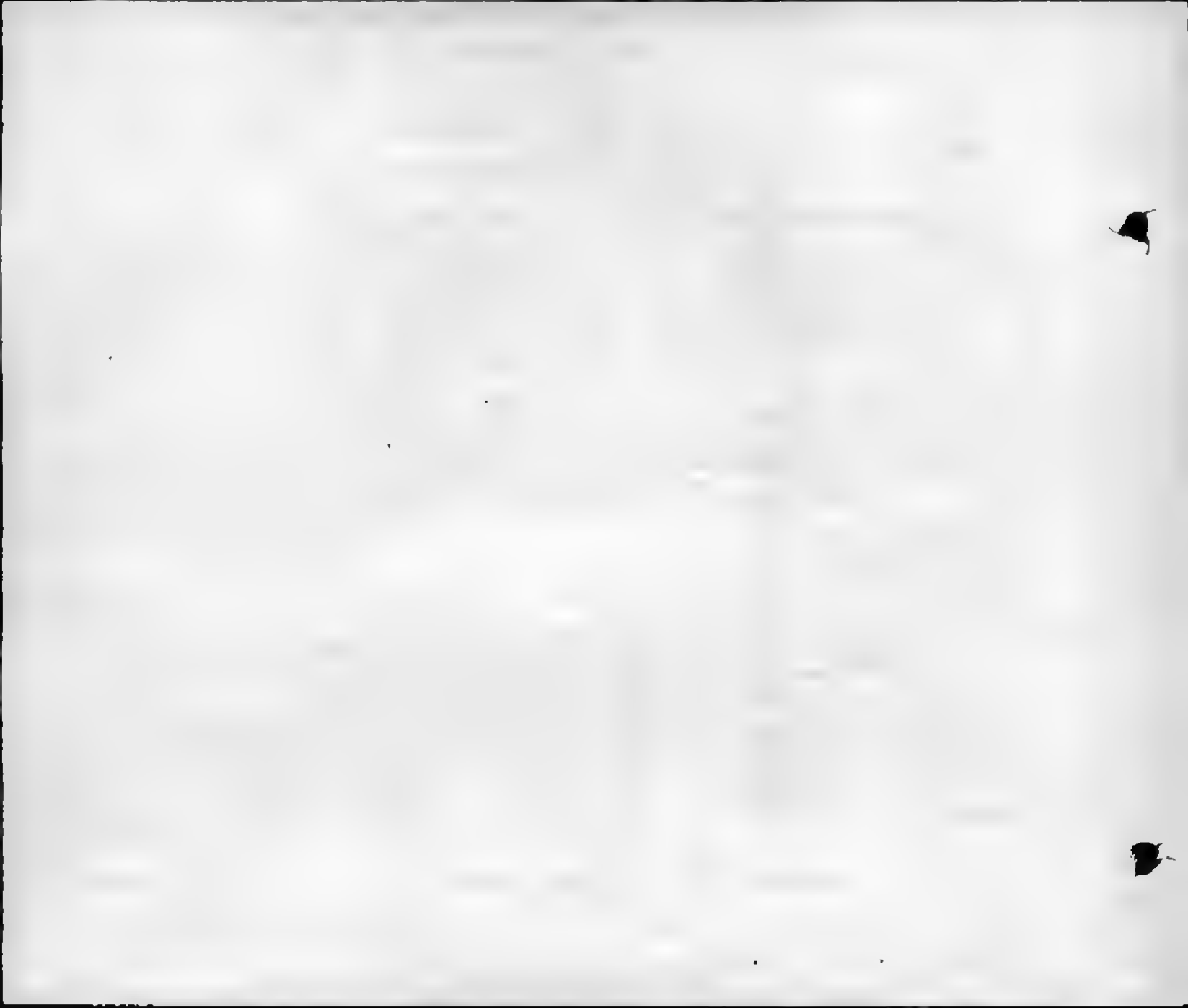
Reg. Dist. No. 09730

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 2 Hour d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY 11/00/166 Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Princess Anne d. STREET ADDRESS Box 366 Rt. #3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Pollitt		4. DATE OF DEATH Month Day Year 8 7 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/60
9. AGE (In years last birthday) — yrs		IF UNDER 1 YEAR Months Days Hours Min. 2	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A.		13. FATHER'S NAME Sidney Hayward	
14. MOTHER'S MAIDEN NAME Sylvia Pollitt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Address Ethel Pollitt, Princess Anne, md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis 162.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 hr
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/7/60 6:30 am to 8/7/60 8:45 am , that I last saw the deceased alive on 8/7/60 , and that death occurred at Princess Anne, Md , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE/SIGNED B. Frank Gigante M.D. 20 Prince William St 8/9/60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) B. FRANK GIGANTE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/8/60	22c. NAME OF CEMETERY OR CREMATORY John Wesley	22d. LOCATION (City, town, or county) (State) Princess Anne, Md
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William H. James Jr. Princess Anne, Md		24a. REC'D BY REGISTRAR DATE AUG 11 '60	24b. REGISTRAR'S SIGNATURE C. Ches S. Harris

1

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



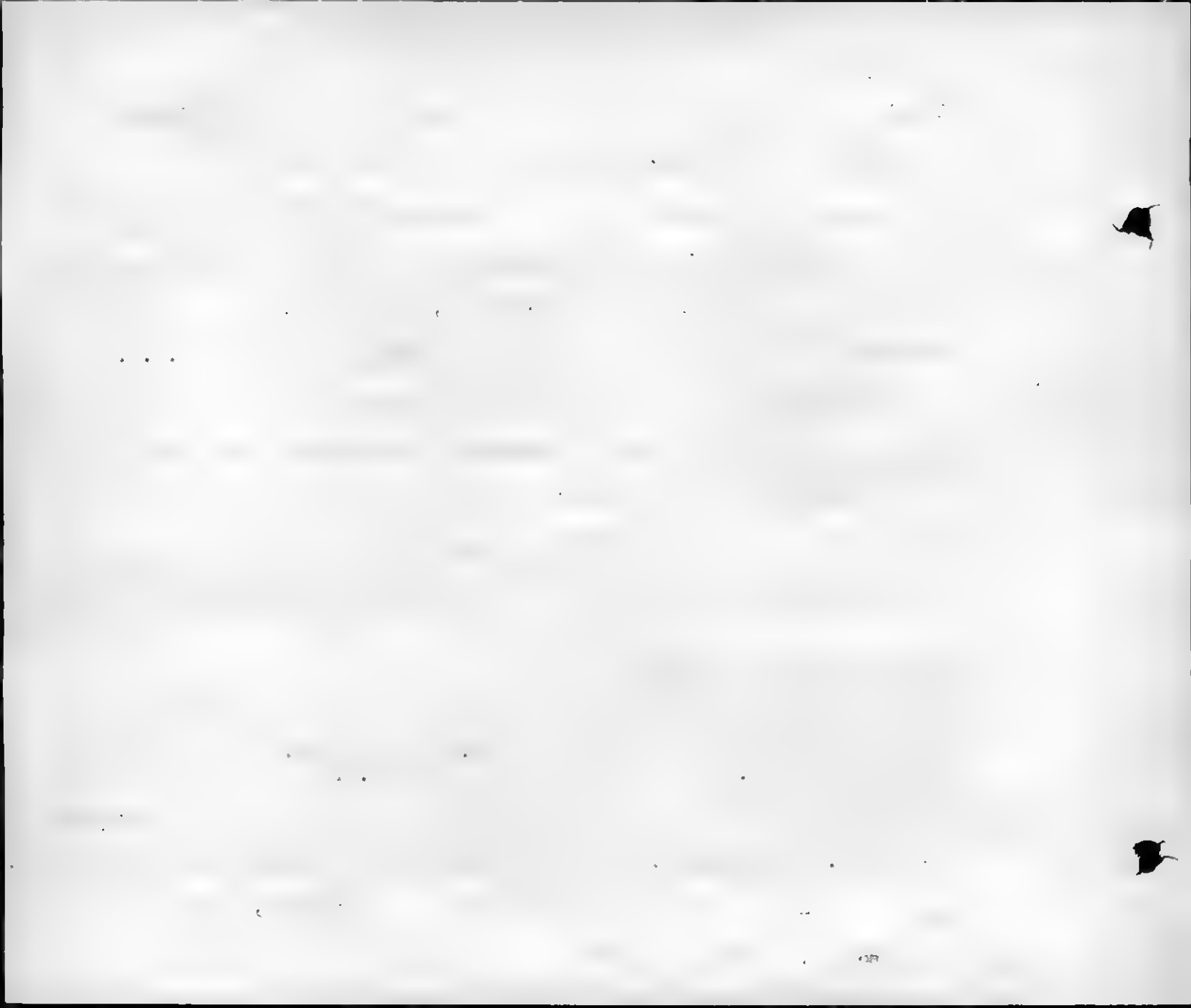
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9755

09731

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b since 8/11/60		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Salisbury		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Bluff State Hospital				e. STREET ADDRESS REF # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last STELLA ELIZABETH PRYOR				4. DATE OF DEATH Month Day Year August 31 19 60			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1883	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Pollitt				14. MOTHER'S MAIDEN NAME Mary Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Records of Pine Bluff State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 yrs							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 11 1960 , to Aug. 31 19 60 that (I) per last saw the deceased alive on Aug. 31 1960 , and that death occurred at 7:02 p.m. the causes and on the date stated above.							
22a. SIGNATURE Edward P. Ritchings				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/31/60	
22c. PHYSICIAN'S NAME (Type) Edward P. Ritchings, M.D.				22d. ADDRESS Pine Bluff State Hospital Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-3-1960		23c. NAME OF CEMETERY OR CREMATORY Union Church Cemetery		23d. LOCATION (City, town, or county) (State) Wicomico, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				ADDRESS Hill & Johnson Co. Salisbury, Maryland		25a. REC'D BY REGISTRAR DATE SEP-2 '60	
				25b. REGISTRAR'S SIGNATURE William S. Thomas			

Norman F. Baber



FOR STATE

HEALTH DEPT.

M

TO DEPT. 7 MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. A delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Wicomico

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

SALISBURY

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

John B. Parsons Home For the Aged

3. NAME OF DECEASED (Type or print)

Martha Elizabeth Reitz

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

DEC. 15, 1869

9. AGE (In years, last birthday)

90

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ALEXANDER

HARLER

14. MOTHER'S MAIDEN NAME

NANCY LONG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

Records: John B. Parsons Home For the Aged

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

904

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Fracture pelvis - left Pelvis

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

Fall

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

7-12-1960

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

Salisbury

(County)

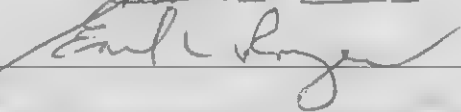
Wicomico

(State)

MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE



M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

8-8-60

EXAMINER'S NAME (Type)

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

8-10-1960

22c. NAME OF CEMETERY OR CREMATORY

Charity Church Cem.

22d. LOCATION (City, town, or country)

SALISBURY MARYLAND

(State)

MD

23. FUNERAL DIRECTOR

Thermost. Wallace, Salisbury, Md.

ADDRESS

Salisbury, Md.

24a. REC'D BY REGISTRAR

DATE AUG 11 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Hines

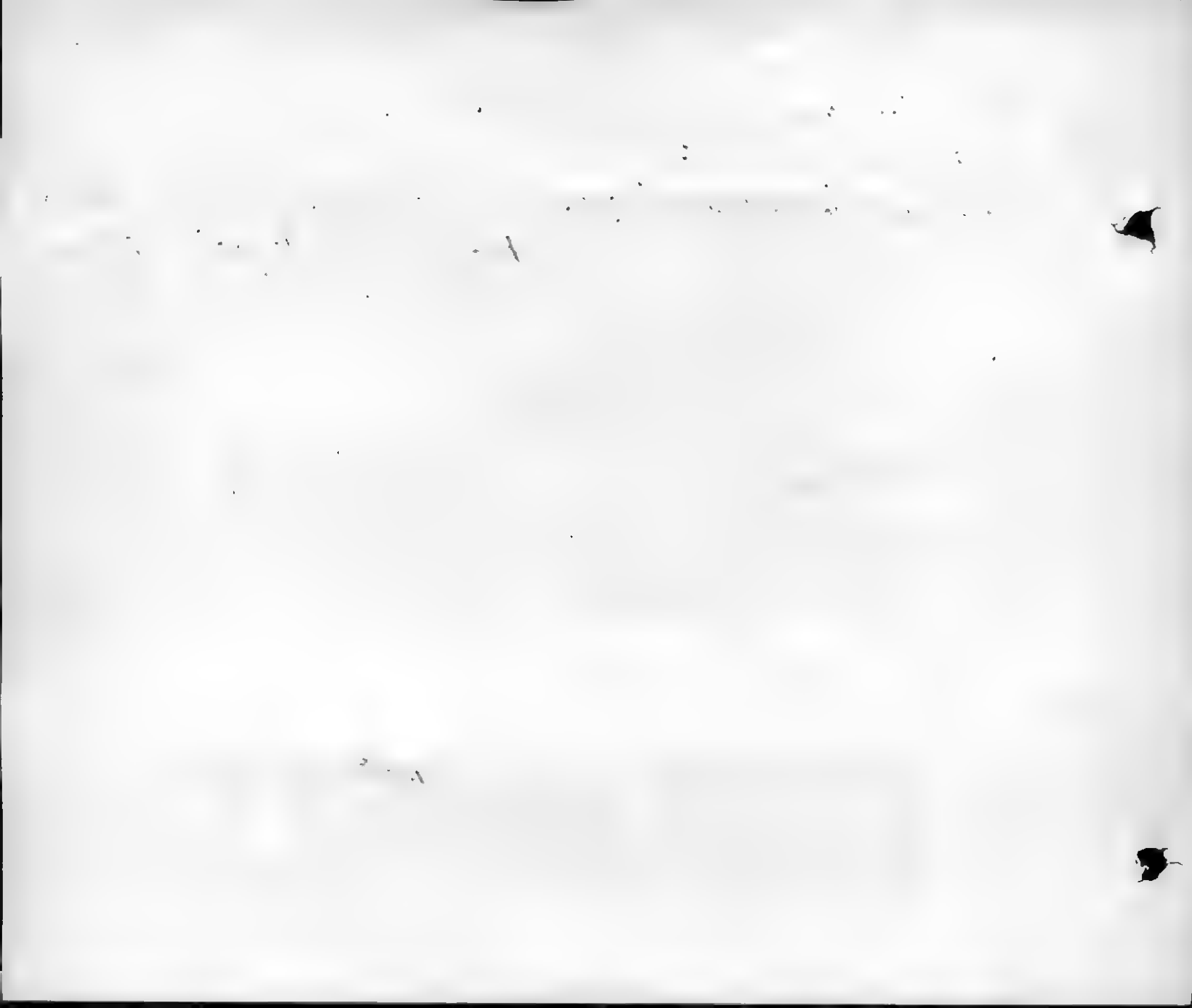


9757

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

09733

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAULIEU OCEAN CITY</u>	
c. LENGTH OF STAY IN 1b <u>6 hrs</u>		d. STREET ADDRESS <u>Rt. 1 The Boardwalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LEO</u> Middle <u>W.</u> Last <u>ROSS</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 10, 1888</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CHM.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DUPONT</u>	
11. BIRTHPLACE (State or foreign country) <u>SHIPPEN TOWNSHIP PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <u>047-06353</u>	
17. INFORMANT <u>Mrs. LEO W. ROSS</u>		Address <u>OCEAN CITY MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURE AORTIC ANEURYSM - ABNORMAL.</u> <u>451X</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 21</u> , 19 <u>60</u> to <u>August 28</u> , 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>August 28</u> , 19 <u>60</u> , and that death occurred at <u>1:35 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William B. Long</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>8/30/60</u>	<u>EVERGREEN</u>	<u>BEAULIEU MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>		25a. REC'D BY REGISTRAR <u>Berlin MD</u>	
25b. REGISTRAR'S SIGNATURE <u>William B. Long</u>		DATE <u>SEP 1 '60</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

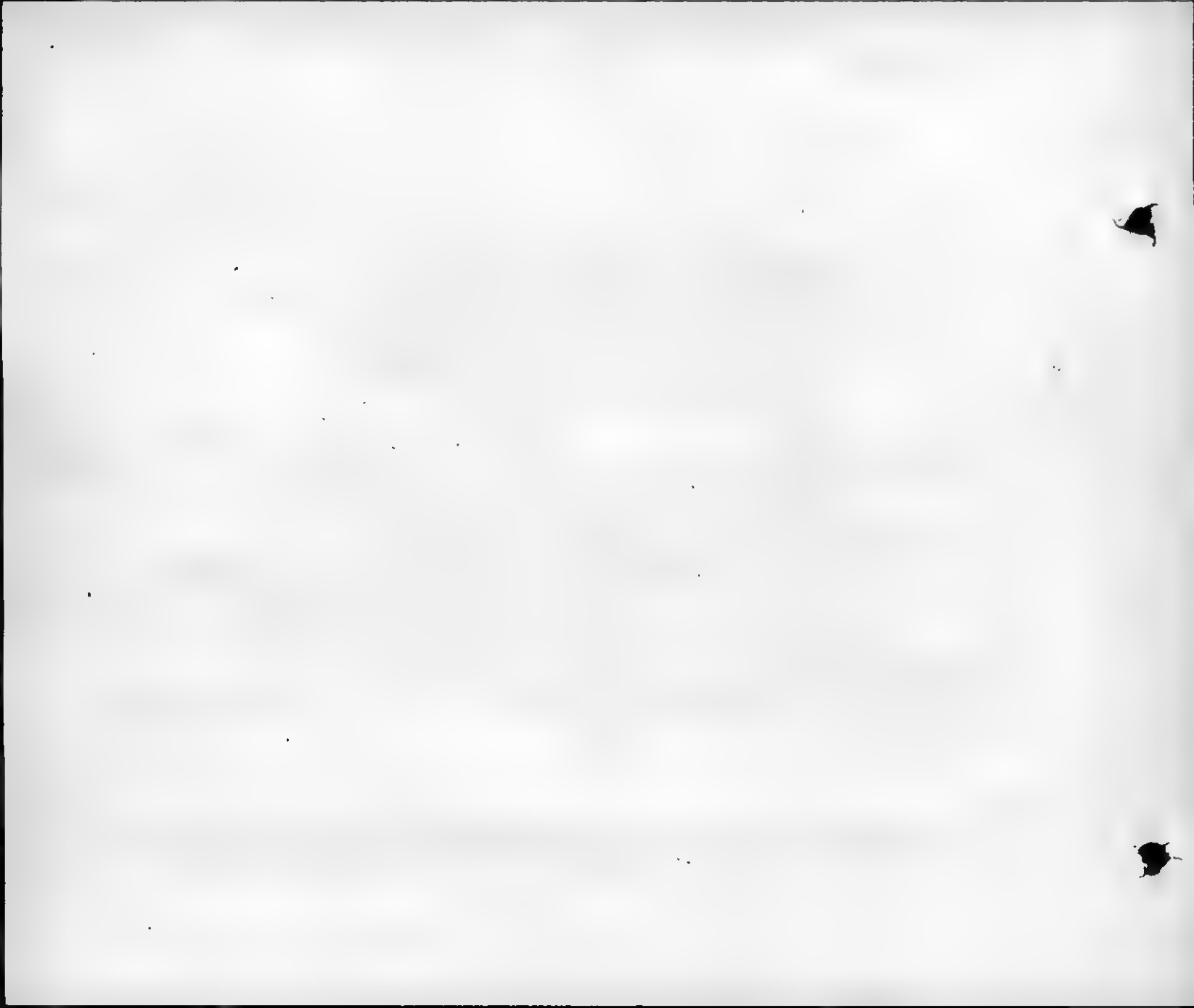
09754

9758

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 5 MINS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X SALISBURY Rt 2.			
d. NAME OF HOSPITAL (If not in hospital, give street address) PENINSULA General Hospital				d. STREET ADDRESS 1 Spring Hill Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph First - Middle - Last Rounds.				4. DATE OF DEATH Month Aug Day 19 Year 1960.			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-10-1903	
9. AGE (In years, last birthday) 56 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELASHA H. Rounds				14. MOTHER'S MAIDEN NAME LAURA POWELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. yes		17. INFORMANT Address MARY E. Dykes Rounds. SAME			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO Arteriosclerotic Heart Disease (c) 3 yrs. INTERVAL BETWEEN ONSET AND DEATH 1 day.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/11 to 8/19 19 60 that (I) (we) last saw the deceased alive on 8/11 19 60 and that death occurred at 9:55 M. from the causes and on the date stated above							
22a. SIGNATURE Rufus S. Gardner Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS Pinebluff Rd, Salisbury, Md			
22c. PHYSICIAN'S NAME (Type) RUFUS S. GARDNER JR.		22d. DATE SIGNED 8/19/60					
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE THEREOF 8-22-1960		23c. NAME OF CEMETERY OR CREMATORY PARSONS Cemetery		23d. LOCATION (City, town, or county) (State) SALISBURY MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co, Salisbury, MD Norman F. Baker				25a. REC'D BY REGISTRAR DATE AUG 23 '60		25b. REGISTRAR'S SIGNATURE Orlinda E. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



9759

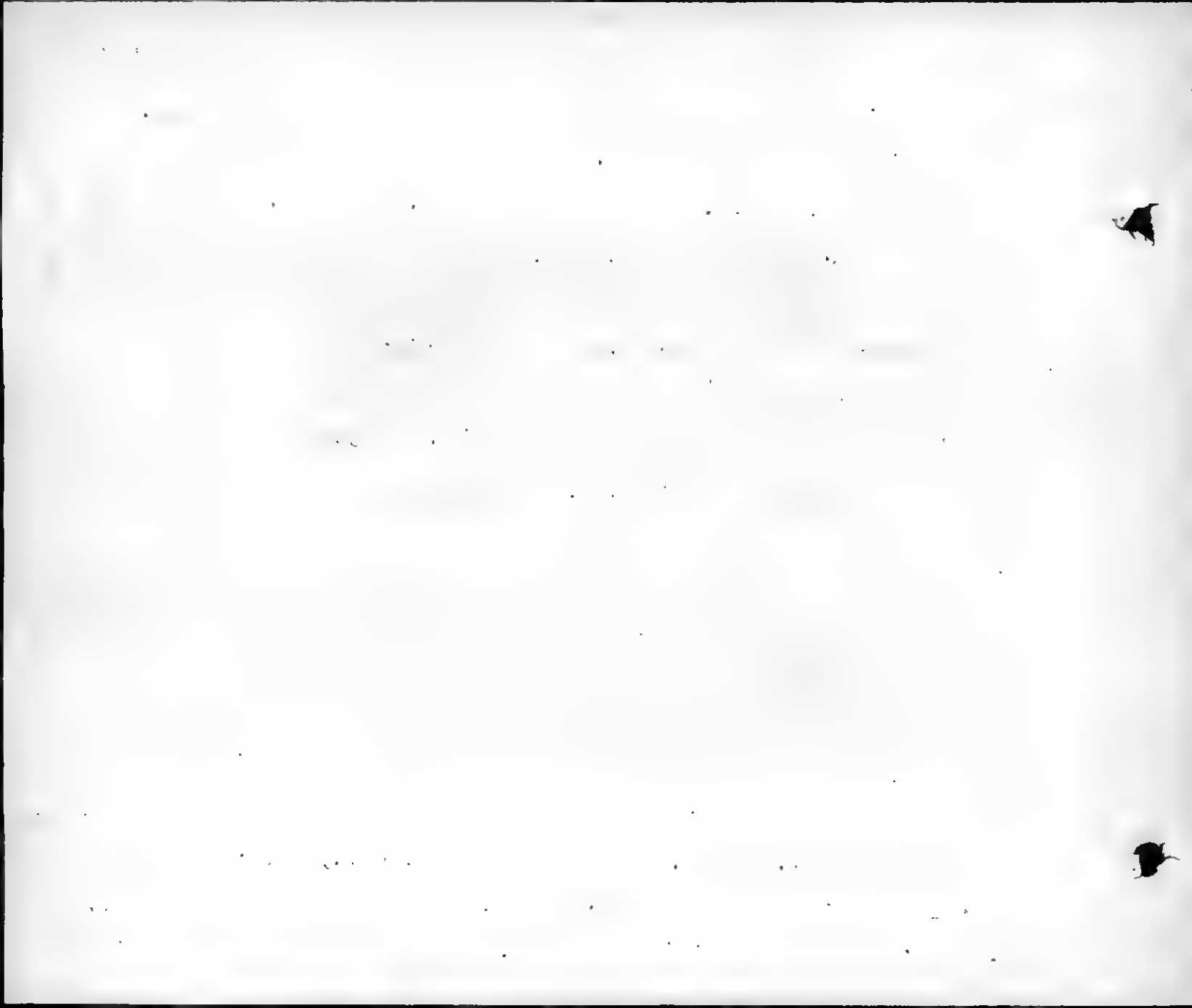
CERTIFICATE OF DEATH

Reg. Dist. No. 09735

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wico.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Sanatorium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORA Middle TULL Last RUARK		4. DATE OF DEATH Month 8 Day 21 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/1866
9. AGE (In years lost birthday) yrs. 93		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Tull		14. MOTHER'S MAIDEN NAME Laura Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Howard H. Ruark, same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): Encephalomalacia		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 22, 1958 to Aug 21, 1960 that I last saw the deceased alive on Aug 16, 1960 and that death occurred at 10:45 AM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Pine Bluff Rd., Salisbury Md.	
ACTUAL SIGNATURE Thomas C. Hill, Jr. M.D.		DATE SIGNED 8/23/60	
PHYSICIAN'S NAME (Type) Thomas C. Hill, Jr.		Pine Bluff Rd., Salisbury	
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/23/1960	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury Md.
23. FUNERAL DIRECTOR'S SIGNATURE Shelby Johnson Co. Salisbury Md.		24a. REC'D BY REGISTRAR AUG 25 '60	
ADDRESS Shelby Johnson Co.		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

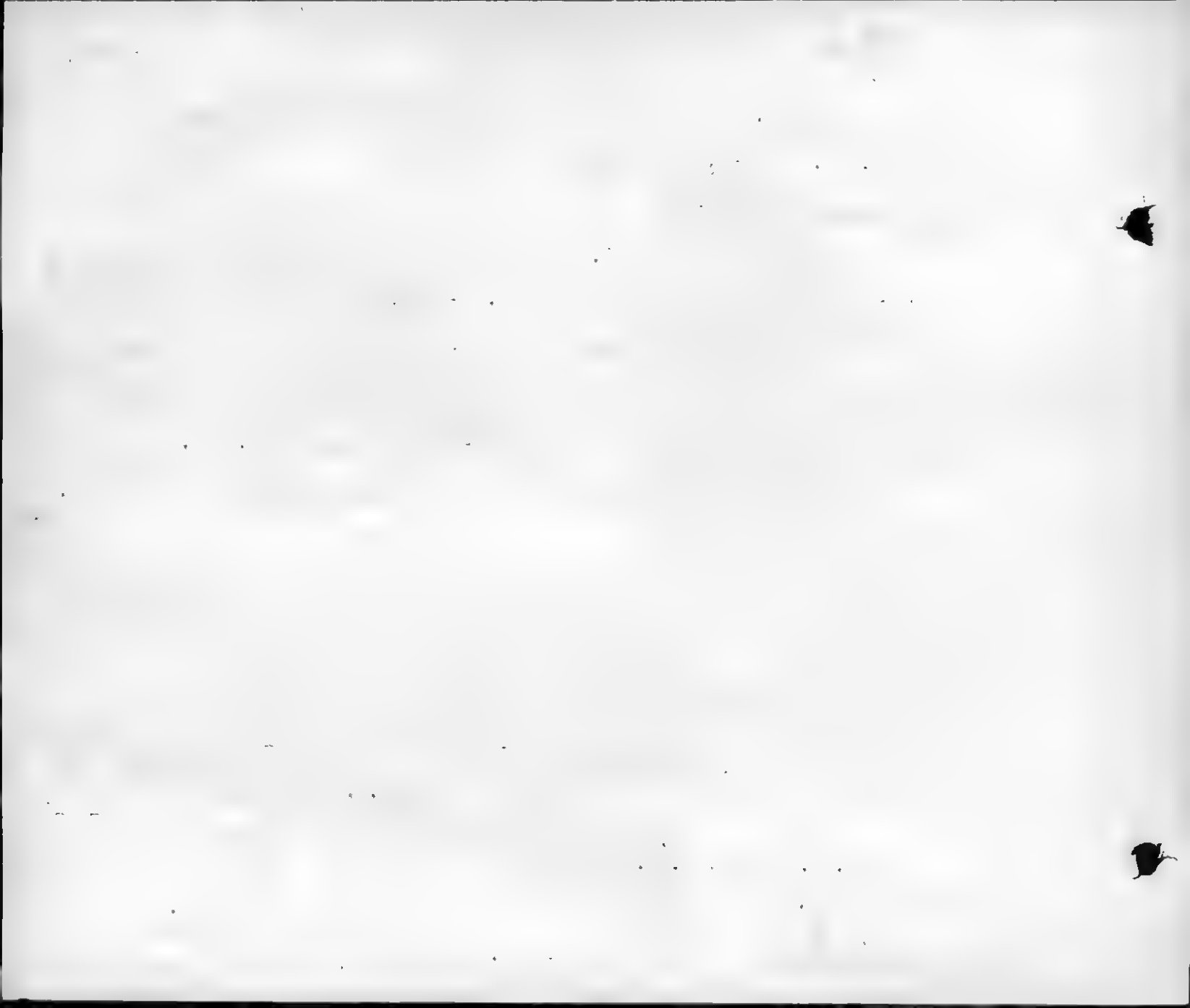
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<div style="display: flex; justify-content: space-between;"> 9760 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 09736 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>											
1. PLACE OF DEATH a. COUNTY <u>Wicomico Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md.</u>				c. LENGTH OF STAY IN 1b <u>118 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>111X-2</u>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>L.</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>19 60</u>							
5. SEX <u>Fem...</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 1-1918</u>		9. AGE (In years last birthday) <u>42</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur Legg</u>				14. MOTHER'S MAIDEN NAME <u>Vickers Crouch</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Thomas Legg-- Rock Hall, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of breast with generalized metastases</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u>60</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>4-21</u> <u>19 60</u> to <u>8-17</u> <u>19 60</u> that (I) (we) last saw the deceased alive on <u>8-17</u> <u>19 60</u> and that death occurred at <u> </u> M, from the causes and on the date stated above											
22a. SIGNATURE <u>L. V. Maldve</u>				22b. DATE <u>3:05 a.m.</u>				22c. PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>			
22d. ADDRESS <u>Deer's Head State Hospital Salisbury, Maryland</u>				22e. ADDRESS <u>Deer's Head State Hospital Salisbury, Maryland</u>							
23a. BURIAL, CREMATION, OR OTHER DISPOSAL <u>Burial</u>				23b. DATE THEREOF <u>Aug. 19</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		23d. LOCATION (City, town, or county) (State) <u>Rock Hall, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>E. Edgar L. Lane</u>				24a. ADDRESS <u>Church Hill, Md.</u>				24b. REC'D BY REGISTRAR <u> </u>		24c. REGISTRAR'S SIGNATURE <u> </u>	

DATE AUG 22 1960

Arthur L. Legg



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

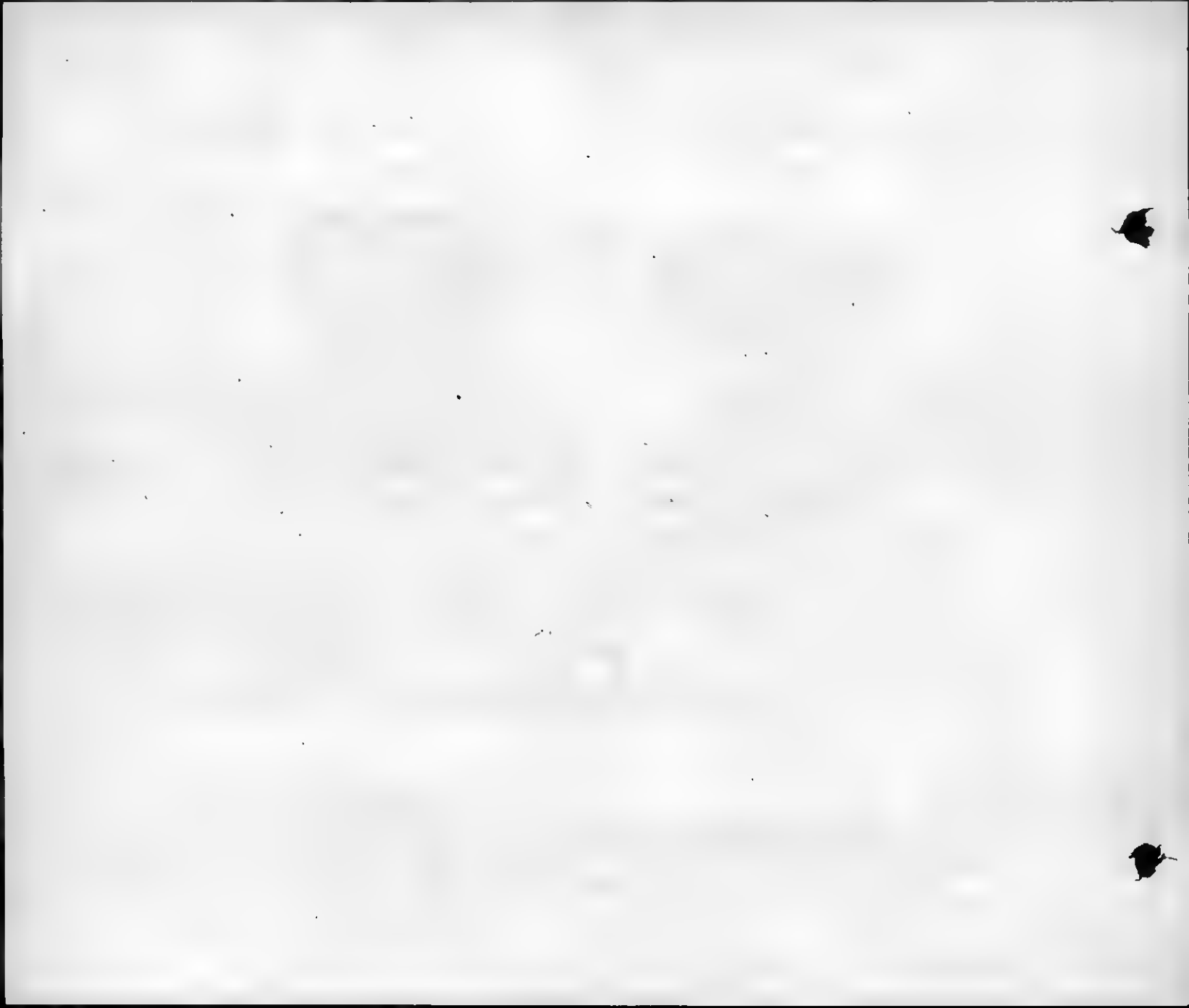
CERTIFICATE OF DEATH

9761

09737

Item 7 Primary Cause of Death

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Jowson</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>13 Skidmore Court</u>	
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>A.</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-1897</u>
9. AGE (In years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Retail Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Office</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Adam Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Silbeck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>212-14-1116</u>	
17. INFORMANT <u>Christine Wells Snyder</u>		Address <u>13 Skidmore Court, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/16</u> to <u>8/20</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8/20</u> , 19 <u>60</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-23-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town, or county) (State) <u>Fredrick Rd. Balto. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service</u>		25a. REC'D BY REGISTRAR <u>AUG 24 '60</u>	
ADDRESS <u>622 YORK Rd</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
9762										
CERTIFICATE OF DEATH										
Reg. Dist. No. 09739										
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>19</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>					d. STREET ADDRESS <u>1903 Heathfield Road</u>					
3. NAME OF DECEASED (Type or print) Mrs. <u>Mabel R. Stockett</u>					4. DATE OF DEATH <u>August 2</u> 19 <u>60</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 29, 1892</u>		9. AGE (In years last birthday) <u>68</u> yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		IF UNDER 1 YEAR: Months Days Hours Min.		
13. FATHER'S NAME <u>Edwin B. Harris</u>					14. MOTHER'S MAIDEN NAME <u>Julia Ann Norwood</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>					16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mrs. Thomas West 1903 Heathfield Road</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MESENTERIC VASCULAR OCCLUSION</u> 750.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u>										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>2 Aug</u> , 19 <u>60</u> , to <u>2 Aug</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2 Aug</u> , 19 <u>60</u> , and that death occurred at <u>3:20</u> M, from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>A. Gray Rees, M.D.</u>					ADDRESS (Street, city or town, state) <u>Medical Center, Salisbury, MD</u>					
DATE SIGNED _____					DATE SIGNED _____					
PHYSICIAN'S NAME (Type) _____										
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>					ADDRESS <u>5305 Hargord Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Hunt</u>	



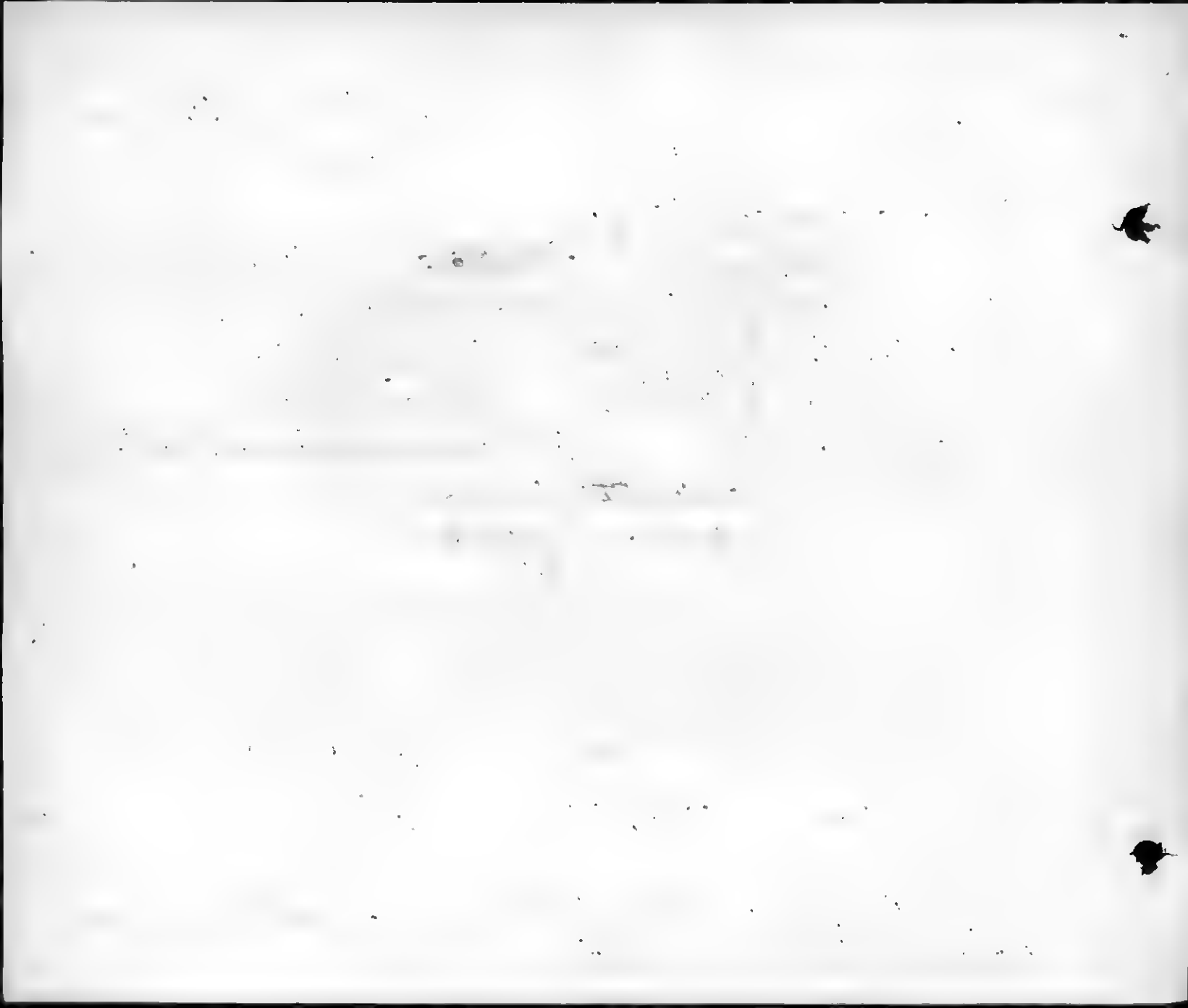
Reg. Dist. No. 09740

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
ISM 9/11

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u>		b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Fruitland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>Ernest</u> Last <u>Strickland</u>				4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 18-1889</u>	
9. AGE (In years last birthday) <u>70 1/2</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u>		11. IF UNDER 24 HRS Hours <u>7</u> Min. <u>13</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Barber Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Key Breeze Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Alfred S. Strickland</u>				14. MOTHER'S MAIDEN NAME <u>Effie Tilghman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes World War I</u>				16. SOCIAL SECURITY NO. <u>2-11-11-11-11-11</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> DUE TO <u>carcinoma of prostate</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) <u>177X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>1 year</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April</u> , 19 <u>60</u> , to <u>Aug 1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug 1</u> , 19 <u>60</u> , and that death occurred at <u>10</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry M. Mally</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
DATE SIGNED <u>8/1/60</u>							
PHYSICIAN'S NAME (Type) <u>Alfred S. Strickland</u>							
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF <u>Aug 4/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alfred S. Strickland</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9764

CERTIFICATE OF DEATH

Reg. Dist. No.

09741

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Franklin ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chambersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		d. STREET ADDRESS 762 Broad Street 75X3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George Franklin First Middle Last		4. DATE OF DEATH August 12 1960 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1913
9. AGE (in years last birthday) 47 yrs		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Store Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Shoe	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William L. Texter		14. MOTHER'S MAIDEN NAME Clara J. Minium	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unkn. (If yes, give war or dates of service) -66---		16. SOCIAL SECURITY NO. 66---	
17. INFORMANT Mrs. Ray Kane Address 250 S. 8th Street Chambersburg, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, acute 42.001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 14 days		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-28 , 19 60 , to 8-12 , 19 60 , that I last saw the deceased alive on 8-12 , 19 60 , and that death occurred at 11:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William R. Ellis M.D.		ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 8-13-60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Co., Penna	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Wallace Salisbury Md ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 15 '60	
		24b. REGISTRAR'S SIGNATURE Carlton S. Kane	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



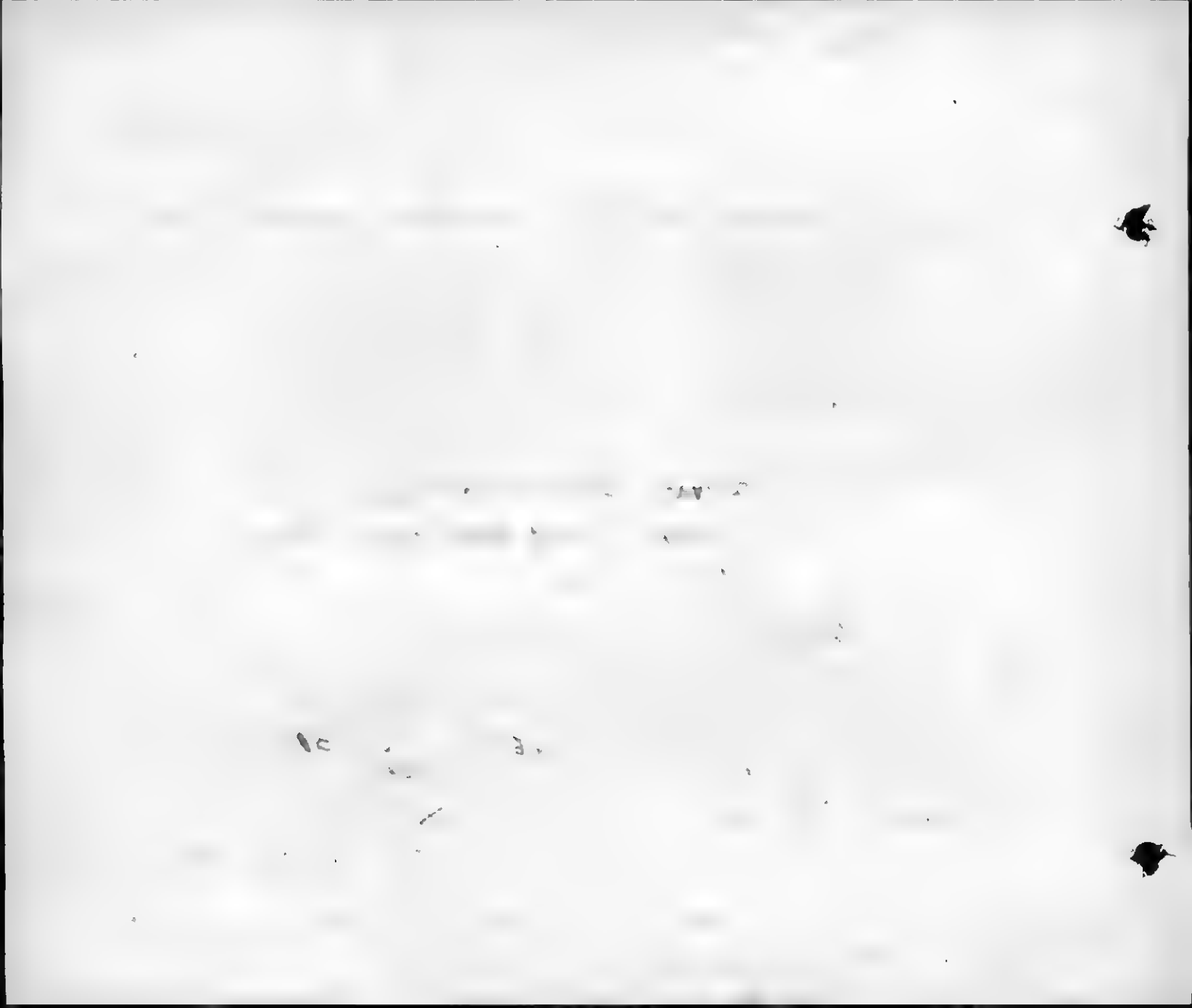
9766

CERTIFICATE OF DEATH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09742

Item 2

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Res. dence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>Route # 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>TRUITT</u> Last <u>TRUITT</u>		4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>August</u> Day <u>16</u> Year <u>1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James T. Collins</u>		14. MOTHER'S MAIDEN NAME <u>Mary Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Eben Truitt Snow Hill Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis Right Middle Cerebral Artery</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>5 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>28 Aug. 1960</u> to <u>30 Aug. 1960</u> , that (I) (we) last saw the deceased alive on <u>31 Aug. 1960</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>		22b. DATE SIGNED	
22c. PHYSICIAN NAME (Type)		22d. ADDRESS <u>707 Camden Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>September 3, 1960</u>	<u>Ebe Nezer</u>	<u>Snow Hill Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart Salisbury Md.</u>		25. REC'D BY REGISTRAR DATE <u>SEP 8 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

970- 9765
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09743

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>102 HICKORY ST.</u>	
3 NAME OF DECEASED (Type or print) First <u>EX</u> Middle <u>LEVI</u> Last <u>TULL</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 9, 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM TULL</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE SAVAGE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-05-8512</u>	
17. INFORMANT <u>MRS VIOLA TULL</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO " Anterior sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) " Anterior sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>0 days</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 17, 1960, to Aug. 23, 1960, that (I) (we) last saw the deceased alive on Aug. 23, 1960, and that death occurred at 11:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>David J. Gilmore</u>		22b. DATE SIGNED <u>8/24/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>		22d. ADDRESS <u>SALISBURY, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-26-60</u>	
23c. NAME OF CEMETERY <u>SALEM METHODIST</u>		23d. LOCATION (City, town or county) (State) <u>Pocomoke City, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Watson</u>		25a. REC'D BY REGISTRAR <u>AUG 29 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur H. Watson</u>		25c. REGISTRAR'S NAME <u>Arthur H. Watson</u>	



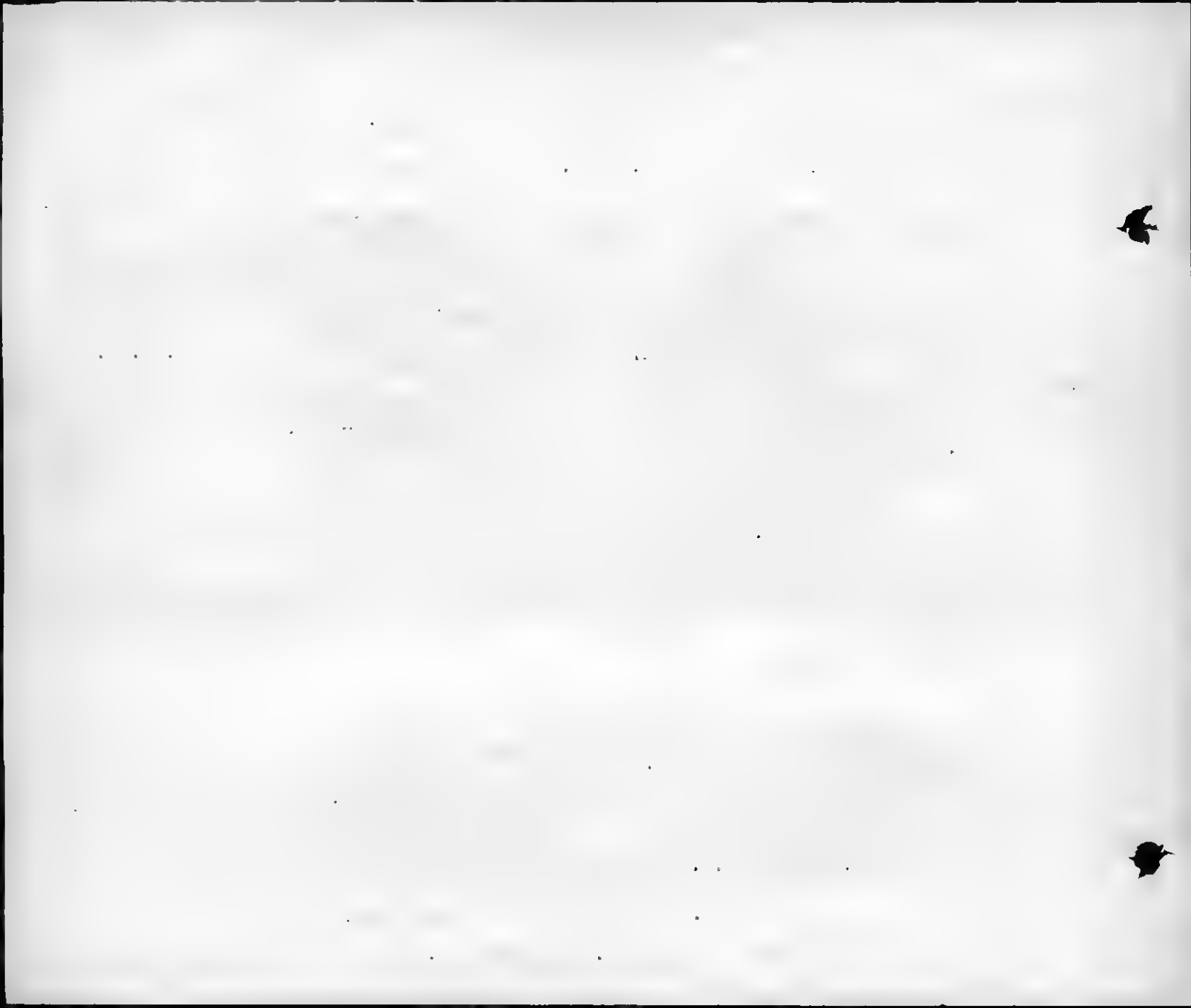
may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the page. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09744

9767

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>			
c. LENGTH OF STAY IN 1b <u>1 Mo. 6 Da.</u>				d. STREET ADDRESS <u>Box 575, Route 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Teresa</u> Middle <u>-----</u> Last <u>Vojtek</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 16, 1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Stephen Novotny (deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth XXXXX Mathia (deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mary Engberg-dgt.</u> Address <u>Hospital Records -- Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>7 Days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>6/29/</u> <u>1960</u> , to <u>8/5/</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>8/5/</u> <u>1960</u> , and that death occurred at <u>4:30</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>L. Maldve</u>				22b. DATE SIGNED <u>August 5, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. Maldve, M.D.</u>				22d. ADDRESS <u>Deer's Head State Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 9, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Belair Rd.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Schimunek Funeral Home</u>				25a. REC'D BY REGISTRAR <u>AUG 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

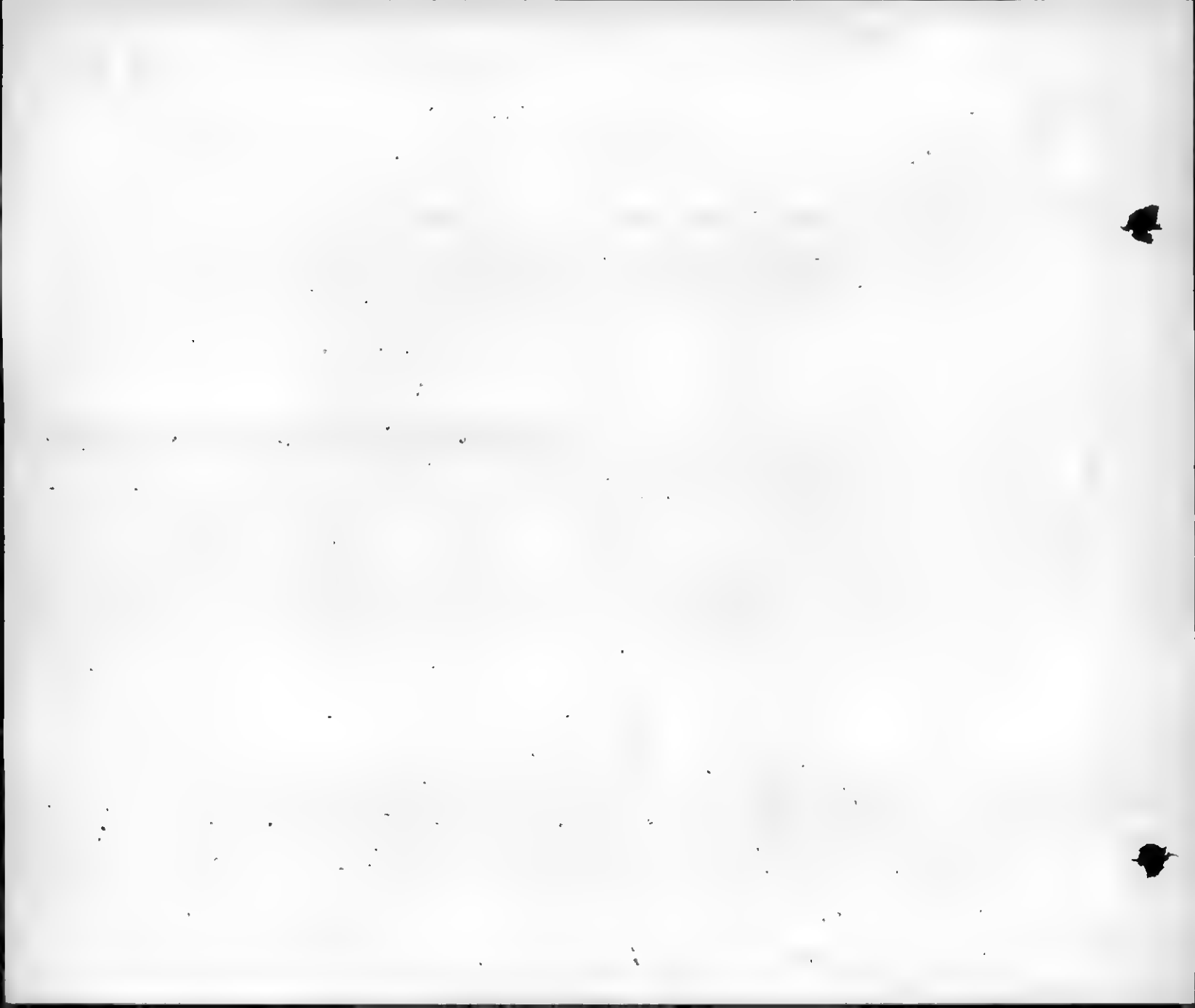
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
9768											
CERTIFICATE OF DEATH											
Reg. Dist. No. 9745											
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Patrick Avenue, City					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Patrick Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First William Middle T. Last Ward					4. DATE OF DEATH Month August Day 28 Year 1960						
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 15, 1900		9. AGE (In years last birthday) 59 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Ward					14. MOTHER'S MAIDEN NAME Ella Boggs						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)					16. SOCIAL SECURITY NO					INFORMANT Mrs. Daisy Austin, Jersey Rd, Salisbury, Maryland Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Bronchopneumonia DUE TO Pleuralitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 days (c) 2 weeks											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that I attended the deceased from Aug 18, 1960 to Aug 28, 1960 that I last saw the deceased alive on Aug 24, 1960 and that death occurred at 7:45 PM from the causes and on the date stated above.											
ACTUAL SIGNATURE G. Herbert Semple, M.D.					ADDRESS (Street, city or town, state) 400 E. Church St. Salisbury, Md.						
PHYSICIAN'S NAME (Type) G. Herbert Semple					DATE SIGNED 9/1/60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Aug. 31, 1960		22c. NAME OF CEMETERY OR CREMATORY Green Acres		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Clinton E. Stewart ADDRESS Salisbury, Md.					24a. REC'D BY REGISTRAR SEP 8 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kenna				

(M)
X

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G-6, 8-17-60 et

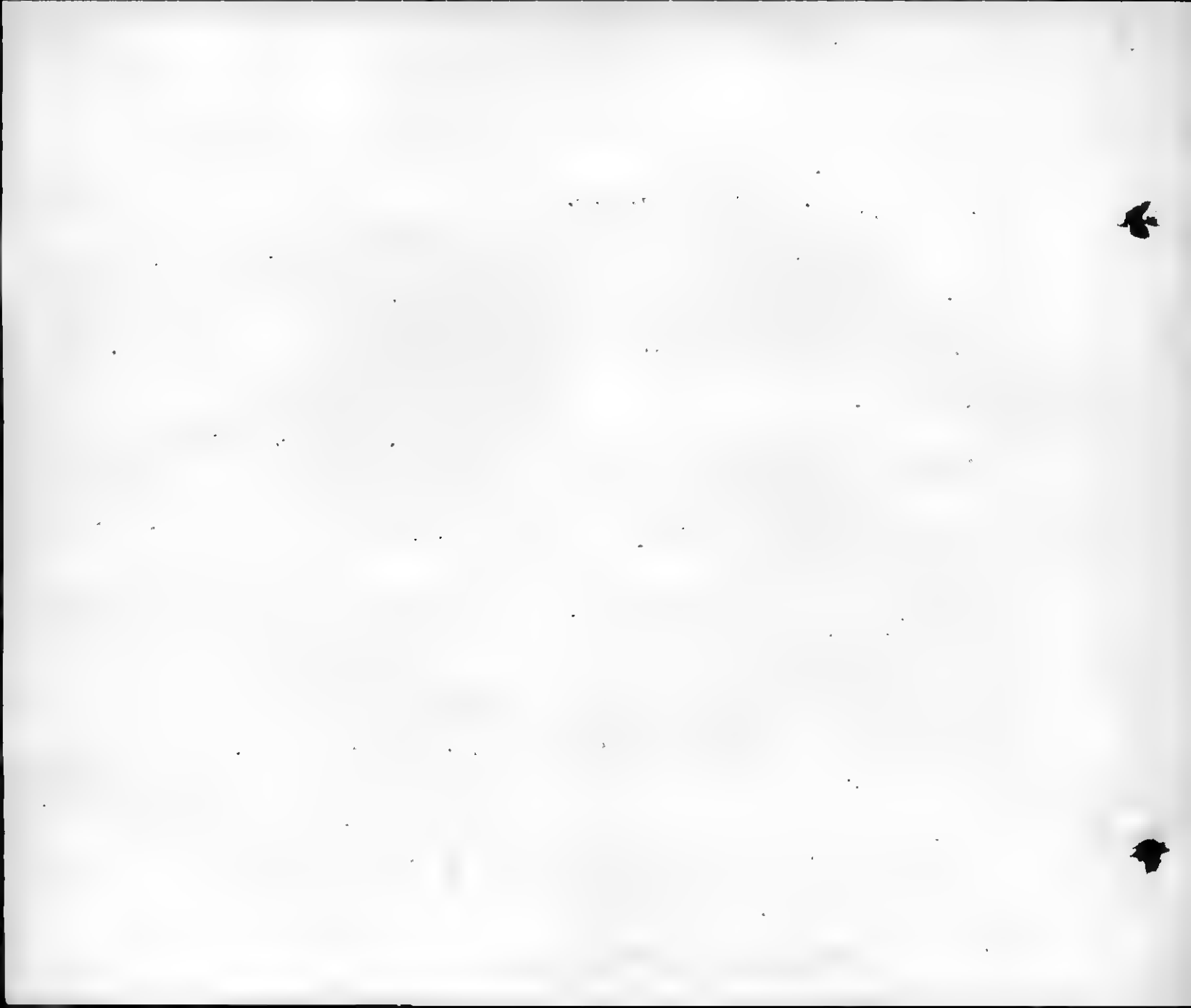
9769

CERTIFICATE OF DEATH

Reg. Dist. No.

09746

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lois</u> First Middle Last <u>WASHINGTON</u>		4. DATE OF DEATH <u>AUGUST 10</u> Month Day Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/15/1919</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chamber Maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>		13. FATHER'S NAME <u>Isaac White</u>	
14. MOTHER'S MAIDEN NAME <u>Lucy Collier</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT Address <u>Isaac White.Princess Anne,Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>00.0</u> DUE TO <u>Chronic pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic pyelonephritis</u> (c) <u>Chronic pyelonephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Long</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension C.V. Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>57</u> , to <u>Aug</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug</u> , 19 <u>60</u> , and that death occurred at <u>12 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>407 E. Main St. An</u> DATE SIGNED <u>8-11-60</u> ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D. PHYSICIAN'S NAME (Type) <u>Earl L. Royer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Paul</u>	22d. LOCATION (City, town, or county) (State) <u>Revel Neck Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr</u> ADDRESS <u>Princess Anne, Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MAY 1960
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09747

Item 2 Film 0271 9-15-60 et

1. PLACE OF DEATH a. COUNTY Wicomico County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 22. Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12. Salisbury, Md. Pocomoke City	
c. LENGTH OF STAY IN 1b 14 months		d. STREET ADDRESS 1. Deer's Head State Hospital	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MOLLIE W. WATERMAN		4. DATE OF DEATH 8 30 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb., 1878
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR: Months 30 Days 19 Hours 60 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ward		14. MOTHER'S MAIDEN NAME Elizabeth Tull	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs Mary Outten, 302 E. Isabella St. Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO (b) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-10 1959 to 8-30 1960 , that (I) (we) last saw the deceased alive on 8-30 1960 and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve, M. D.		22b. DATE SIGNED 8-31-60	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-3-60	
23c. NAME OF CEMETERY Forest Lawn		23d. LOCATION (City, town, or county) (State) Norfolk, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson		25a. REC'D BY REGISTRAR SEP 6 '60	
ADDRESS Pocomoke City, Md.		25b. REGISTRAR'S SIGNATURE Charles E. Evans	

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardella Springs		c. LENGTH OF STAY IN 1b 10 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home		d. STREET ADDRESS 22 Muir street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Richard Last Willey		4. DATE OF DEATH Month August Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min. 85	11. IF UNDER 24 HRS. Months 85 Days 85 Hours 85 Min. 85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Painter		10b. KIND OF BUSINESS OR INDUSTRY Dorchester County	
11. BIRTHPLACE (State or foreign country) Dorchester County		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Richard C. Willey		14. MOTHER'S MAIDEN NAME Elizabeth Barber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Howard Hubbard, 13 Cemetery Ave., Cambridge	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis/Heart DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.0 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1960 to Aug 8, 1960 that I last saw the deceased alive on Aug 8, 1960 , and that death occurred at 64 M , from the causes and on the date stated above.			
ACTUAL SIGNATURE H. S. Kuhlman		M.D. Sturgeson, J. W.	
PHYSICIAN'S NAME (Type) H. S. Kuhlman		DATE SIGNED 8/10/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 11, 1960	
22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shorrock		24a. REC'D BY REGISTRAR DATE AUG 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOPEFUL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEED

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